PREMIER SURGICAL OF WISCONSIN, S.C.

Written Acknowledgement of Receipt

I acknowledge that I have received the written Notice of Privacy Practices and office brochure with financial policy of Premier Surgical of Wisconsin S.C.

Consent to Use & Disclosure of Protected Health Information

I consent to the use or disclosure of my protected health information by Premier Surgical of Wisconsin,S.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Premier Surgical of Wisconsin, S.C.

I also give my permission to Premier Surgical of Wisconsin, S.C. that the following designated person(s) are allowed access to my health records (such as test results, billing inquiries, progress updates, phone conversations, etc).

_____

_____

_____

Name Relationship

Patient Request for Confidential Communication

If there is a need to communicate my protected health information other than at an appointment in the office, I am authorizing Premier Surgical of Wisconsin, S.C. the right to communicate my protected health information to me in the following manner:

Yes	No		Physicians or staff may leave a message on my answering machine
Yes	No		Physicians or staff may call me at home to discuss my health care
Yes	No	N/A	Physicians or staff may call me at work for an appointment change
Yes	No	N/A	Physicians or staff may call me at work to discuss my health care

Authorization for Assignment of Benefits

I authorize my insurance benefits to be paid directly to Premier Surgical of Wisconsin S.C., realizing I am responsible to pay deductibles, co-payments &/or my co-insurance % portion, and non-covered services (with the exception of contractual discounts).

_____ _____

Patient or personal representative . Date

_____

(If personal representative – give relationship)