Erland Internal Medicine

Acknowledgement and authorization

Name: _____ DOB: _____

Please initial each line, sign, and date below:

_____ I have read and understand the HIPPA/Privacy Policy of Erland Internal Medicine.

_____ I hereby assign my insurance benefits to be paid directly to Erland Internal Medicine.

_____ I authorize Erland Internal Medicine to release medical information required to process my claim.

_____ I understand the financial policy of Erland Internal Medicine.

_____ I authorize Erland Internal Medicine to leave information regarding my medical care and test results on my voicemail.

_____ I understand Erland Internal Medicine may charge me a late cancellation/no show fee of $100.00. That I could be terminated after 2 late cancellation/no show.

** Erland Internal Medicine is authorized to discuss my medical care and/or tests results with:

Name: _____ Relationship: _____

Contact Number: _____

Signature: _____ Date: _____