Patient name: ________________________________ **SSN:** _____________ **DOB:** ____________

Acknowledgment of Receipt of Notice of Privacy Practices

Bloomington Medical Services reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Bloomington Medical Services. **Initial** __________

Authorization to Release Information

By signing below, I authorize Bloomington Medical Services to release medical information to the following:

Name of authorized person	Relationship to patient	Phone
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

By signing below, I authorize Bloomington Medical Services to leave a message on my phone at the following number: ____________________ **Initial** __________

Phone number

Insurance & Financial Authorization

By signing below, I signify that I understand that my insurance benefits are an agreement between my insurance company and me for payment of services I receive. I am authorizing Bloomington Medical Services to bill my insurance for services rendered. I received a copy of the financial policy and agree to its terms. I understand that under Ohio law, I may request a list of usual and customary charges and rates.

I understand that I may be contacted by Bloomington Medical Services and/or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and/or automated dialing services (“auto dialer”) , or by text message or email in connection with any communication made to me or related to my accounts, even if I am charged for the call under my phone plan. **Initial** __________

Authorization to Obtain Medication History

By signing below, I hereby authorize Bloomington Medical Services physicians to obtain my medication history from community pharmacies and/or pharmacy benefit managers for the purpose of continued treatment.

Initial __________

____ ______________________________

Signature (patient/parent or guardian/legal representative) **Date**