PATIENT-CLINIC AGREEMENT

Harrison Hasanuddin, DO
張宏彬 醫學博士

AUTHORIZATION TO TREAT

I (or the undersigned on behalf of the patient) voluntarily consent to allow Dr. Harrison Hasanuddin and his staff (“The Clinic”) to provide medical evaluation, care, and treatments as an outpatient on a continuing basis, as determined by The Clinic to be advisable and necessary.

I am advised that such evaluation and treatment may include physical examination, laboratory procedures, imaging studies, sleep studies, and other office procedures.

I understand that I will be informed about the course of my treatment. Also, I am free to terminate my treatment with The Clinic at any time.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges, whether or not paid by my insurance unless specifically exempted by my insurance company's contract with The Clinic.

ASSIGNMENT OF BENEFITS

I hereby assign medical benefits, private insurance, and any other health plan benefits to Harrison Hasanuddin, D.O., Inc. A copy of this assignment is considered valid as the original.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize The Clinic to release any medical information necessary to my insurance company or its agents in order to secure payments. Please review The Clinic’s Notice of Privacy Practice Form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I read and received a copy of this medical practice's Notice of Privacy Practices.

I certify that I have read the foregoing and have received a copy. As the patient, the patient's guardian, conservator, or general agent, I agree to accept the above terms.

Patient name: ____

Signature: __________________________ Date: __________________

☐ I am the patient’s Legal Guardian. Full name: _________________________

OFFICE USE

REV’D BY _____