MAIN LINE INSTITUTE of PLASTIC SURGERY

RYAN S. HOFFMAN, MD, FACS
Board Certified Plastic Surgeon

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Ryan Hoffman, M.D., to use and disclose health information about me for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Ryan Hoffman, M.D., have a Notice of Privacy Practices, which describes the rights and limitations of the patient and the practice. My signature hereto will acknowledge receipt and acceptance of the rights and limitations therein and my personal copy of said Notice.

I understand that if I do not furnish the correct insurance information, including a referral which is accepted for payment by the referring insurance company, when necessary, or my insurance company denies payment of services, I am financially responsible for my amount due and owing to Ryan Hoffman, M.D. I also accept responsibility for payment of any services that my insurance company determines as my responsibility—as as co-payments, deductibles, or a charge that is not a covered service under my insurance policy.

_____ _____

(Name of Patient) **(Date)**

_____ _____

(Name of Personal Representative) **(Date)**

_____

(Relationship to Patient)

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