Dr. Stuart. M. Podell - Dr. Sonia Valle - Dr. Alison Schmidt
77 Veterans Memorial Highway
Commack, NY 11725

SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to PVC and/or its providers for services furnished to me. I authorize any holder of medical information about me to be released to _____or any other of my medical
(name of your insurance)
carriers or any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of original.

1) **SIGNATURE:** _____ **DATE:** _____

PRIVACY POLICY

I have been informed that PVC has a privacy policy in place. I understand that this policy is posted in the office. I am aware that I may receive a copy of the policy at my request.

2) **SIGNATURE:** _____ **DATE:** _____

CONSENT TO RELEASE INFORMATION: (PLEASE CIRCLE YES OR NO)

1. I permit the practice to release my medical information to the physicians involved in my care. **YES OR NO**
2. I permit the practice to **call** my home or other designated location and leaving a message on voicemail or in person in reference to my care and treatment, appointment reminders, insurance items. **YES OR NO**
3. I permit the practice to **mail** to my home any medical records, appointment reminders, patient statements. **YES OR NO**
4. I permit the practice to **email** information pertaining to my care, treatment, appointments, insurance items, patient statements and medical records. I have been informed that the email will be sent through an unencrypted format and I understand that there is a risk for a breach of confidentiality. **YES OR NO**
5. I permit the practice to **text** information pertaining to my care, treatment, appointments, insurance items, patient statements and medical records. I have been informed that the email will be sent through an unencrypted format and I understand that there is a risk for a breach of confidentiality. **YES OR NO**

3) **SIGNATURE:** _____ **DATE:** _____

I designate the following representative(s) who the provider can communicate with on my behalf (i.e. Friend, spouse, son, or daughter) If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.

_____ _____
Name Relationship

_____ _____
Name Relationship

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR USE OF NON-PARTICIPATING PROVIDERS

I hereby acknowledge and understand that under the terms of my insurance plan should I at anytime and for whatever reason utilize the non-emergent services of any non-participating provider (including but not limited to doctor, laboratory, radiology and other ancillary services) I may not be covered in whole or in part of the associated costs and will bear the full financial responsibility for the costs of such services.

4) **SIGNATURE:** _____ **DATE:** _____