Disclosure to Families and Loved Ones (Emergency Contacts)

I authorize Megumi Maguchi, MD to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These Individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Megumi Maguchi, MD to disclose my personal health information to the following people.

Name_____ Relationship_____ Phone ( ) _____

Name_____ Relationship_____ Phone ( ) _____

Name_____ Relationship_____ Phone ( ) _____

Consent to Treatment for All Patients

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for and understand that no guarantee or assurance has been made as to the results for which may be obtained _____

Patient Initials

Photo Documentation

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record. _____

Patient Initials

Notice of Privacy Practices

I have received a copy of the Megumi Maguchi, MD "Notice of Privacy Practices" today and agree with these privacy policies _____

Patient Initials

Insurance Assignment and Financial Responsibility

I hereby authorize the offices of Megumi Maguchi, MD to release any medical information required during the course of examination and treatment to my insurance company and I permit payment to Megumi Maguchi, MD from my insurance of coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all changes incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Megumi Maguchi, MD. _____

Patient Initials

_____ _____

Date Signature of Patient or Guardian (If Patient is Minor)