MAX HEALTH MAINE, LLC
A FAMILY PRACTICE

MaxHealthMe
TERRY ANN SCRIVEN, MD

**PERMISSION FOR ASSIGNMENT OF INSURANCE BENEFITS,
PERMISSION TO DISCLOSE HEALTH INFORMATION,
AND TO COMMUNICATE BY EMAIL, PHONE and TEXT**

Patient
Name:_____ _____ __ Date of Birth:___/___/_____
(First Name) (Last Name) (MI)

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Max Health Maine or Dr. Scriven for services rendered to my dependents or me by the physician, or persons under her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due over sixty days that Max Health Maine is unable to collect from my insurance carrier for whatever reason. *Initial___*

MEDICARE/MAINECARE INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Max Health Maine or Dr. Scriven on my behalf.

Initial___

AUTHORIZATION TO RELEASE AND RECEIVE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have reviewed/read and been offered a copy of the Patient Information Privacy Policy mandated by federal law. I have declined a copy. I hereby authorize Max Health Maine or Dr. Scriven to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits; and to down load and input (from the external pharmacy data base) all of the medications prescribed for me in the last 15 months.

Initial___

AUTHORIZATION TO MAIL, CALL, TEXT OR E-MAIL:
I certify that I understand the privacy risks of phone calls, text and e-mail. I hereby authorize Dr. Scriven and/or a representative of Max Health Maine, to call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results, and any personal health information if I chose to communicate using these means. I understand that I have the right to rescind this authorization at any time by notifying Max Health Maine/Dr. Scriven to that effect in writing. I will not use email for urgent appointment requests or matters.

Initial___

LAB/X-RAY& DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Initial___

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by Dr.Scriven or her designee. *Initial___*

BY SIGNING BELOW I AGREE TO ALL PERMISSIONS DESCRIBED ABOVE.

PATIENT SIGNATURE: _____ DATE:_____

GUARANTOR SIGNATURE: _____ (Guarantor not patient)

GUARANTOR NAME(Print:) _____ DATE:_____

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