Release and HIPAA

I hereby give my consent for Dr. Theodore Diktaban to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent; Dr. Theodore Diktaban reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Theodore Diktaban privacy Officer at 1016 5th Avenue, New York, NY 10028.

With this consent, Dr. Theodore Diktaban may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Dr. Theodore Diktaban may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and material related to my clinical care as long as it is marked Personal and Confidential.

With this consent, Dr. Theodore Diktaban may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, marketing information and material pertaining to my clinical care. I have the right to request that Dr. Theodore Diktaban restrict how it uses or discloses my PHI to carry out my TPO. Dr. Theodore Diktaban is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Theodore Diktaban use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Theodore Diktaban may decline to provide treatment to me.

_____ _____

SIGNATURE of Beneficiary, Guardian or Personal Representative Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

CONSENT TO PHOTOGRAPH

I consent to be photographed during the course of my treatment with Dr. Theodore Diktaban. I understand that the purpose of such photographs is to track the progress of my treatment(s). I understand that my photographs are part of my medical records and, therefore, are the property of Dr. Theodore Diktaban.

Patient's Signature: _____ Date: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

Below, please list the name(s) and relationship of any person other than yourself that you authorize Dr. Theodore Diktaban to release your medical information to.

I authorize the following third parties (i.e. spouse, parent, and partner) to view or receive verbal information regarding my record(s): **OTHERWISE**, □ Please check here if you **do not authorize** release of my medical information to any third parties.

_____ _____

Print Name Relationship

_____ _____

Print Name Relationship

INSURANCE AND BILLING INFORMATION

Who is responsible for this account? _____Relationship to Patient _____
Social Security # _____ DOB _____ Insurance Company Name _____
ID# _____Group/Policy#_____

INSURANCE PLAN REQUIREMENTS, ASSIGNMENT

I am fully aware that Theodore Diktaban, M.D. **only** participates with Oxford and United Healthcare insurance and that he is non-participating with all other medical insurance carriers. If I am not covered by Oxford or United healthcare insurance, it is my responsibility to know whether or not my medical insurance carrier offers out-of-network benefits for non-participating physicians. I acknowledge and agree that I am fully responsible for any/all co-payment, co-insurance, and deductible and/or other claim amount that my insurance company terms "patient responsibility".

I certify that I (and/or my dependent(s)) have insurance coverage with the above named insurance company (ies) and assign directly to Dr. Theodore Diktaban, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Theodore Diktaban may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I am fully aware that if my health insurance company requires a referral from my primary care physician in order to process and pay my medical claims, it is my responsibility to obtain it prior to being treated by Dr. Diktaban. I understand that without a valid referral form, my visit is an unauthorized visit and therefore reimbursement will not be provided by my insurance carrier. In the event my referral does not arrive or is dated after the date of receiving services from Dr. Theodore Diktaban, I understand that I am fully responsible for payment for the treatment I receive.

I understand that any treatment I receive that is of a cosmetic nature will not be submitted to or covered by my insurance carrier and that I am responsible to pay the full cost that Dr. Theodore Diktaban has determined to be appropriate for the treatment I receive.

_____
Patient Name (Print)

_____ _____
Patient's Signature Date

IF PATIENT IS A MINOR (UNDER 18 YRS. OF AGE)

_____ _____
Signature of Parent/Legal Guardian (if minor) Date

_____ _____
Print Name of Parent/Legal Guardian Relationship