

● I authorize Dr. Robert Cooper's office to release my medical records to my insurance company(s) and to act as my agent in helping me to obtain payment from my insurance company(s). I authorize my insurance company(s) to make payment directly to Dr. Robert Cooper, Jr. I understand that Dr. Cooper is a participating provider with Medicare. _____

● *I also understand that I am personally responsible for my billing including any amount not covered by my insurance except in cases of a contractual agreement between my insurance carrier and my physician.) If my account becomes delinquent, and collection proceedings become necessary, I understand that I am responsible for attorney fees, court costs, and a 30% collection fee.* _____

● My signature also acknowledges that I have read and understand the policies that will be followed by this, the office of Dr. Robert Cooper, Jr., in order to adhere to all requirements implemented by any and all HIPPA laws. All privacy acts will be honored by all personnel of this office and I will initial by each of the following for the methods I authorize Dr. Cooper's Office to leave medical information pertaining to my care:

Home phone/voice mail_____Mobile phone/voice mail_____Work phone/voice mail_____

Fax medical records for referrals to another entity: Yes_____No_____

Please list name(s) of other persons that may obtain information on your behalf:

Date:_____

Signature

Date:_____

(If minor, signature of parent or guardian is required)