Darrick E. Antell, M.D., P.C.

Insurance

Insurance may be applicable for some reconstructive and medically necessary procedures. Please indicate your coverage below.

Name of Insurance Company:_____

Policy and Group Number:_____

Name of Policy Holder:_____ SS#:_____

Patient Acknowledgement Form & Chaperone Policy

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy. (See Insert)

At any time, at the request of the patient, we are happy to provide you with a chaperone. Some patients would feel more comfortable having another person in the examination room, in addition to themselves and Dr. Darrick Antell. This may be a friend or family member, or a member of our staff. Your comfort is one of our primary concerns, and we value this. Simply address your request for a chaperone to Dr. Darrick Antell or anyone on our staff, and we will accommodate you.

Chaperone Requested: YES_____ NO_____ (Please initial one choice)

Choosing "Yes" means that you ***REQUIRE*** one of ***Dr. Antell's staff members*** to be present, along with Dr. Antell, during the entirety of your consultation.

Minors must always be accompanied by a parent or legal guardian when a physical examination is performed, or one of Dr. Darrick Antell's staff will be present at the examination. At the minor's request, and with the parent or legal guardian's agreement, the minor may be examined without the parent or legal guardian in the examination room.

On rare occasions, in an emergency, Dr. Darrick Antell may see you after hours in his office or at your home. At such time, no office staff is available to serve as a chaperone. Should such an occasion arise, Dr. Darrick Antell requires that you be accompanied by a family member or friend.

By signing this form you acknowledge that you have been informed of our use and disclosure of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our notice has been provided to you: that you understand the contents of our Notice, how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____/_____/_____

Name Date