HIPPA Toolkit Form E
Notice and Acknowledgement

Acknowledgement:

I acknowledge that I received the attachment Notice of the Privacy Practices.

_______________________________________ Date_______________
Patient or Personal Representative Signature

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: ____________________________

Information can be released to: ______________________________________

Supplier, Provider or Group
"One time authorization "
Statement to permit payment of Medicare benefits to Providers, Physicians and Patients

Dr. Alan W. Solway, M.D
Dr. Christopher R. Papp, M.D.
Name of Physician

_________________ Payment to Patient ____X____Payment to Provider

Patient Signature: _________________________________ Date______________

Provider Signature: _________________________________ Date______________

Provider Name: Alan W. Solway M.D., Dr. Christopher R. Papp, M.D.

For services furnished to inpatient of a hospital or SNF, this request is effective for the period of confinement. For services furnished by a provider or on an outpatient basis, this request is effective until revoked by the beneficiary.

For durable medical equipment- this procedure is limited to assigned claims, because of the danger or incorrect payment that could otherwise result if the patient dies, recovers or goes into an institution and must be renewed if a new item is rented or purchased. The supplier assumes unconditional responsibility for funding any payments that may result because the carrier did not receive prompt notice that DME had been returned or is no longer needed or the enrollee has died or been institutionalized.

Note: This statement must be maintained for each patient individually.