

ASSIGNMENT OF BENEFITS & PAYMENT /CREDIT AGREEMENT

(This is necessary to facilitate the processing of insurance claims and assure payment.)

1. I hereby authorize and give permission for Njideka E. Udochi, MD, MFP, FAAFP, and the Millennium Family Practice, LLC to disclose my personal health information (PHI)* for insurance and treatment purposes only. I am allowing Dr. Njide Udochi and the Millennium Family Practice, LLC to release all PHI necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical benefits to which I am entitled, including Medicare, private insurance and any other insurance.
3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-pays, and that payments are due at the time services are rendered.
4. I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay collection agency's pay fees for collection, court cost, and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance.
5. This office reserves the right to change a handling fee for any unpaid balance.

Acknowledgement of Receipt of Privacy Notice – I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and subject to the following restriction(s) I have made concerning my personal medical information, I agree to the disclosures named in the notice.

Federal law ensures the privacy of your medical records, their availability to you, and specific rights regarding your medical records.

Dr. Njide Udochi and Millennium Family Practice, LLC comply with these standards. As a general principle, we will always assume that you have instructed us **NOT** to release your medical records, or any portion thereof, to anyone except under the usual general circumstances covered below.

Please read and sign this **GENERAL AUTHORIZATION CONCERNING YOUR MEDICAL RECORDS**.

Relevant portions of my medical record may be provided to:

1. Other designated doctors and their staffs (e.g., this practice; primary and referring doctors and their staff; hospitals or out-patient facilities, endoscopy unit, or surgical-day-care).
2. My medical insurance company to document specific service(s) provided and billed.
3. The government, as required by law (e.g., subpoena)

If you wish to designate (a) person(s) (**other than those listed above**) to be given access to all or part of your medical record, please initial "ACCESS ALLOWED" below and write their names(s):

_____ **Access allowed** **Name(s):** _____

If you have any questions, comments or exceptions, please speak with our practice Administrator.

I acknowledge that I have read, understand, and agree to the above information regarding benefits and payment/credit agreement, privacy notice and medical records.

(Print Name)

(Date)

(Signature)

Acc #. (Office Use Only)