

**Dove Family Clinic, Inc**  
**PATIENT INTAKE FORM**

**PATIENT INFORMATION**

|                 |            |                |                        |          |               |     |
|-----------------|------------|----------------|------------------------|----------|---------------|-----|
| Last Name       | First Name | Middle Initial | Social Security Number |          |               |     |
| Street Address  |            | City           | State                  | Zip Code | Date of Birth | Age |
| Primary Phone # |            | Email Address  |                        |          |               |     |

☐ Male   ☐ Female   ☐ Single   ☐ Married   ☐ Divorced   ☐ Separated   ☐ Widow

**PRIMARY INSURANCE**

Holder: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Member id: \_\_\_\_\_  
Phone: \_\_\_\_\_

**SECONDARY INSURANCE (if applicable)**

Holder: \_\_\_\_\_  
Insurance Co: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Member id: \_\_\_\_\_  
Phone: \_\_\_\_\_

**EMPLOYER**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Phone: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Phone 1: \_\_\_\_\_  
Phone 2: \_\_\_\_\_

May we share personal medical information?   ☐ Yes   ☐ No

**CURRENT MEDICATIONS**

|  |
|--|
|  |
|  |
|  |

**ALLERGIES**

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|--|
|  |
|  |
|  |

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
(If guardian, write name please)

\_\_\_\_\_  
Date

*Dove Family Clinic, Inc*  
**PATIENT MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

| Yes                      | No                       |                          | Yes                      | No                       |                              | Yes                      | No                       |                            |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS                     | <input type="checkbox"/> | <input type="checkbox"/> | Head Injury                  | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Disease        |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                  | <input type="checkbox"/> | <input type="checkbox"/> | Headaches                    | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever              |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                   | <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems or Disease    | <input type="checkbox"/> | <input type="checkbox"/> | Scarring / Keloids         |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism    | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis – type:            | <input type="checkbox"/> | <input type="checkbox"/> | Seizures / Convulsions     |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                   | <input type="checkbox"/> | <input type="checkbox"/> | Herpes                       | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of Breath        |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Problems            | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure          | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble              |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                   | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive                 | <input type="checkbox"/> | <input type="checkbox"/> | Skin Rash                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Carotid Artery Disease   | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                     | <input type="checkbox"/> | <input type="checkbox"/> | Special Diet / Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemical Dependency      | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain                     | <input type="checkbox"/> | <input type="checkbox"/> | Spinal Injury              |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy             | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease               | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Circulatory Problems     | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease                | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Feet or Ankles     |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Treatments     | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure           | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Neck Glands        |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough                    | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease                 | <input type="checkbox"/> | <input type="checkbox"/> | Temporal Arteritis         |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                 | <input type="checkbox"/> | <input type="checkbox"/> | Migraines                    | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems           |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Problems             | <input type="checkbox"/> | <input type="checkbox"/> | Tonsilitis                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                 | <input type="checkbox"/> | <input type="checkbox"/> | Neurological Disease         | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizziness    | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Disorder            | <input type="checkbox"/> | <input type="checkbox"/> | Tumors or Growths          |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Disease | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorder or Care | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                 | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatment          | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease           |

**ADDITIONAL QUESTIONS**

| Yes                      | No                       |                                                                                  | Yes                      | No                       |                              |
|--------------------------|--------------------------|----------------------------------------------------------------------------------|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink? # per day _____                                                    | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant or nursing?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? # per day _____                                                    |                          |                          | Date of last menstrual cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you vape? <input type="checkbox"/> Cannabis <input type="checkbox"/> Nicotine |                          |                          |                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use any edible cannabis or CBD products?                                  |                          |                          |                              |

**Allergies**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous hospitalizations / surgeries**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other medical concerns / reason for visit**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient / Guardian Name: \_\_\_\_\_

Patient / Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# **Dove Family Clinic, Inc**

## **Medical Record Release Authorization**

### **Patient Information:**

- Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- Address: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
- Phone Number: \_\_\_\_\_

**Authorization:** I authorize Dove Family Clinic, Inc to ☐ obtain my medical records from Recipient/entity below ☐ release my medical records to the following individual/entity:

- Name of Recipient: \_\_\_\_\_
- Address: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
- Phone Number: \_\_\_\_\_

**Purpose of Release:** This authorization is for the purpose of:

☐ Continuity of Care ☐ Legal Representation ☐ Insurance Claim ☐ Personal Records ☐ Other (please specify): \_\_\_\_\_

**Records to Be Released:** Please specify the medical records to be released. You may choose to release all records or specify particular documents, dates, or categories of information:

- ☐ All Medical Records
- ☐ Specific Documents/Dates/Categories (please specify): \_\_\_\_\_

**Method of Release:** ☐ Electronic Transmission (Please provide email address or secure portal information): \_\_\_\_\_

☐ Paper Copy

☐ Fax (Please provide fax number): \_\_\_\_\_

**Expiration Date:** This authorization is valid until (please specify date): \_\_\_\_\_

**Patient's Signature:** *I understand that I have the right to revoke this authorization at any time by providing written notice to [Dove Family Clinic, Inc]. I also understand that once my medical records are disclosed, they may no longer be protected by federal or state privacy laws.*

**Patient's Full Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Dove Family Clinic, Inc*  
**NOTICE OF PRIVACY PRACTICES**

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PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

I have received, reviewed, and understand this practice's Notice of Privacy Practices written in plain language. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me an updated Notice of Privacy Practices upon request.

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Patient / Guardian Signature

(If guardian, write name please)

Date

*Dove Family Clinic, Inc*  
**CREDIT / DEBIT CARD AUTHORIZATION**

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PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method.

1. I understand that the Provider will submit billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from this Provider, including those covered by my insurance.
2. I understand that payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider.
3. I understand that I may be charged a service fee or service may be denied for failure to pay a co-pay or any outstanding balance at the time of service.
4. I understand that it is my responsibility to ensure that the Provider has current information on file, at all times, including my address, contact details, insurance information, and a valid credit/debit card or other payment information.
5. I understand that my signature and payment information will be held on file for future use by the Provider.
6. I understand that the Provider may offer an automated payment plan option, if available, and that this convenience may incur interest charges.
7. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures, or supplies, including (i) amounts agreed as part of a payment plan, (ii) co-payments, (iii) co-insurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
8. I understand that I may receive a monthly statement for any outstanding balance that is not satisfied by a charge to my payment method and that I am responsible for paying this balance by its due date.
9. I understand that unpaid balances may incur additional fees and interest charges.
10. I understand that I may not be provided with advance notice of authorized payments and any advance notice that is given is done so as a courtesy of the provider. Transactions will be maintained in the patient file.
11. I authorize the Provider and/or its designated payment agent to send electronic account statements, invoices, and receipts to the email address I have provided to this office. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.
12. I understand this authorization will remain in effect until the expiration of the credit card or until I provide a 30-day written notice of cancellation to the Provider.

**ACKNOWLEDGMENT AND AUTHORIZATION:**

By signing this form (i) I acknowledge that I have received, reviewed, and understand the Provider's payment policies, (ii) I authorize the Provider and/or its designated payment agent to charge my credit/debit card in accordance with the payment policy, and (iii) I certify that I am an authorized cardholder or user of this credit/debit card.

Name on Card: \_\_\_\_\_ Email Address: \_\_\_\_\_

Credit Card # \_\_\_\_\_ CVV: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover EXP: \_\_\_\_\_

\_\_\_\_\_  
Cardholder's Signature

\_\_\_\_\_  
Date

## ***Dove Family Clinic, Inc***

Please List Pharmacies: (Please include mail order pharmacies as well)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

***Dove Family Clinic, Inc***  
Consent to Treat Form

1. I \_\_\_\_\_ (patient name) give permission for **Dove Family Clinic, Inc** to give me medical treatment.
  
2. I allow **Dove Family Clinic, Inc** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Dove Family Clinic, Inc** will have to send my medical record information to my insurance company.
  - I must pay my share of the costs.
  - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- 
3. I understand:
    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical treatments with my clinician.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature  
(for children under 18)

\_\_\_\_\_  
Date

# Dove Family Clinic, Inc

## HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### PROVIDER, FACILITY, OR INDIVIDUALS AUTHORIZED TO RELEASE, REQUEST, AND DISCUSS PERSONAL HEALTH INFORMATION:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I, the patient, hereby authorize the Provider, Facility, or Individuals listed above to release, request, and discuss my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members, physicians, clinics and/or hospitals:

NAME: \_\_\_\_\_ Phone [H]: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone [M]: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

NAME: \_\_\_\_\_ Phone [H]: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone [M]: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ Phone [H]: \_\_\_\_\_  
Type: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ Phone [H]: \_\_\_\_\_  
Type: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ Phone [H]: \_\_\_\_\_  
Type: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ Email: \_\_\_\_\_

May we identify ourselves over the phone? ☐ Yes ☐ No

May we leave messages? ☐ Yes ☐ No

Length of Authorization: ☐ 6 months ☐ 1 year ☐ 3 years ☐ From: \_\_\_\_\_ To: \_\_\_\_\_

I hereby discharge the releasing facility, its agents, and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, request, or discussion of information authorized herein, including alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Patient / Guardian Signature

(If guardian, write name please)

Date

***Dove Family Clinic, Inc***  
**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION**

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**YOUR RIGHTS AND RESPONSIBILITIES**

You have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. You may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, you must do so in writing and send it to the appropriate disclosing party.

You understand that uses and disclosures already made based upon your original permission cannot be taken back.

You understand that it is possible that information used or disclosed with your permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

You understand that treatment by any party may not be conditioned upon your signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that you may have the right to refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment except to the extent that the information being released or requested may assist your healthcare provider in determining the appropriate treatment. Refusal to sign this authorization will not affect your eligibility for benefits.

You will receive a copy of this authorization after you signed it. A copy of this authorization is as valid as the original.

This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.

You have the right to inspect the information you are authorizing to be released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices.

The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.

Unless otherwise specified by law, we will release only that information that has been created by our employees or agents, including chart notes, lab results, summaries, and consultations. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

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Patient / Guardian Signature

*(If guardian, write name please)*

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Date

# ***Dove Family Clinic, Inc***

1109 7<sup>th</sup> Avenue  
Glenmora, La. 71433  
PH: (318) 579-8019  
FAX: (318) 656-3181

## **Assignment of Benefits**

**Patient Name** \_\_\_\_\_

This Assignment of Benefits and Authorization applies to all claims for services rendered in the past, present, and future, whether or not such claims have been submitted, denied, appealed, paid, or remain outstanding at the time of this agreement.

In consideration of medical and/or mental health services to be provided, I, the undersigned, acknowledge that I have insurance and/or employee health care benefits coverage with the above-captioned entity, and I hereby assign and convey directly to Dove Family Clinic, Inc all medical and mental health benefits, reimbursements, and insurance proceeds otherwise payable to me for services, treatments, therapies, or medications rendered by the Practice regardless of the Practice's managed care network participation status.

This assignment and authorization expressly authorize Dove Family Clinic, Inc to take any and all necessary steps to secure payment, including but not limited to: submitting and resubmitting claims, pursuing administrative appeals, requesting disclosures and remedies, filing suit, and exercising all other legal rights available under federal or state law in my name and stead for the collection of all medical and/or mental health benefits otherwise payable to me.

The Patient hereby assigns and conveys to Dove Family Clinic, Inc and/or their designated business associates (as defined under 45 C.F.R. §160.103) all rights, title, and interests in and to any and all benefits the Patient is entitled to receive under the Patient's health plan or insurance policy, including but not limited to the right to recover such benefits. The Patient authorizes Dove Family Clinic, Inc to release all medical and mental health information necessary to pursue and process such benefits and claims.

Designation of Billing Company and Business Associate Authorization: I further designate and authorize New Leaf Billing, Coding, and Auditing Solutions, LLC ("NLBCAS"), the Practice's contracted billing and revenue cycle management company, to act as my Designated Authorized Representative and Business Associate under 45 C.F.R. §160.103 for the limited purpose of performing billing, coding, claim submission, payment posting, appeals, and related administrative services on behalf of the Practice.

This designation expressly authorizes NLBCAS to communicate directly with my health plan, plan administrator, fiduciaries, and any third-party administrators; to obtain and exchange protected health information (PHI) as necessary for claim adjudication, payment, and appeals; to request and receive claim files, plan documents, and EOBs; and to take any reasonable actions necessary to secure and recover benefits due under applicable law, including but not limited to ERISA §503 and §502(a).

NLBCAS shall operate solely within the scope of its Business Associate Agreement with the Practice and shall at all times maintain compliance with HIPAA, the Affordable Care Act, ERISA, and all applicable state and federal

privacy laws. This designation does not transfer ownership of benefits but confers authority to act administratively to facilitate billing, payment, and appeal functions as permitted by law.

The Patient certifies that the health insurance information provided is accurate and agrees to update it as necessary. The Patient authorizes the Dove Family Clinic, Inc to submit claims on the Patient's behalf (and/or on behalf of the Patient's dependents or legal representation, guardianship) to the benefit plan (or its administrator), to be paid in full accordance with the governing plan document, policy terms, and applicable federal and state law.

The Patient expressly designates, authorizes, and appoints the Provider, its attorneys, and/or its designated business associates as the Patient's authorized representative to:

1. Release any information necessary to the health benefit plan (or its administrator) regarding the Patient's illness, care, and treatment.
2. Submit and process insurance claims for services rendered.
3. File and participate in any administrative or judicial review process, including appeals under ERISA §503 and related regulations.
4. Pursue payment for benefits, enforce rights, and file suit for benefits and any fiduciary breach under ERISA §§502(a)(1)(B), 502(a)(3), and related provisions.
5. Exercise all remedies and causes of action wholly in the Patient's stead, including recovery of benefits, statutory penalties, and attorney's fees for any failure by the plan, fiduciary, or claims administrator to comply with applicable laws.
6. Obtain all disclosures and plan documents required under ERISA §104(b)(4) and pursue penalties under §502(c)(1) for failure to provide.
7. Authorize the use of a photocopy of this signature for purposes of processing claims.

This authorization and assignment shall remain in full force and effect until all benefits are paid in compliance with applicable federal and state laws, including but not limited to ERISA, HIPAA, and the Mental Health Parity and Addiction Equity Act.

I further authorize and direct my health benefit plan, its fiduciaries, claims administrator(s), plan administrator(s), and/or any third-party administrators to release to my health care provider / Practice and/or the Provider's appointed business associates all electronic data interchange (EDI) information, claim-related information, and any other records necessary for Dove Family Clinic, Inc or their business associate to secure and recover benefits on my behalf. This authorization expressly includes, but is not limited to, a complete copy of the administrative claim file and any investigative claim file, as applicable.

I hereby instruct my benefit plan (or its administrator) to remit payment for all covered services rendered to me and/or my dependents, legal representation, guardianship directly to Dove Family Clinic, Inc. Such payment shall be made in full compliance with the governing plan document, applicable federal and state laws, and without offset against unrelated claims.

I hereby authorize Dove Family Clinic, Inc to collect, negotiate, and receive all payments of medical and/or mental health benefits due to me under any applicable insurance policies or health benefit plans. I agree to cooperate as needed in securing all benefits to which I am entitled for healthcare services rendered.

To the extent that my current policy or plan contains any provision prohibiting or restricting direct payment to a practice / provider, I hereby instruct and direct my benefit plan (or its administrator) to provide, upon request, a copy of the governing plan document and the specific provision relied upon to deny assignment, consistent with applicable federal and state law.

In the event proof of such a non-assignment clause is produced, I further instruct my benefit plan (or its administrator) to issue benefit payments in my name and mail such payment(s) directly to Dove Family Clinic, Inc for deposit.

I acknowledge that state and federal consumer protection laws including those applicable to out-of-network providers may support my right to assignment and direct payment. Dove Family Clinic, Inc is hereby authorized to

execute any documents necessary to perfect this assignment of insurance benefits and payments directly to Dove Family Clinic, Inc for all services rendered.

I understand, agree, and certify that I am financially responsible for all charges incurred, including but not limited to copayments, co-insurance, and deductibles, regardless of any applicable insurance or benefit payments. I further acknowledge that I am responsible for the full amount of all charges billed, whether or not such services are covered by my health insurance or benefit plan.

To the best of my knowledge, I am not aware of any exclusions or limitations under my health plan that would prevent payment for the healthcare services rendered by the above-listed provider. I understand that payments are due at the time services are rendered unless otherwise subject to applicable PPO network adjustments or ACA-mandated discounts once my claim has been processed in full compliance with plan terms and governing laws.

I hereby authorize the Dove Family Clinic, Inc to release any and all medical information necessary to process claims for benefits related to my care.

I hereby authorize any plan administrator, fiduciary, insurer, or attorney to release to Dove Family Clinic, Inc, its attorneys, or designated business associate, New Leaf Billing, Coding, and Auditing Solutions, LLC upon written request, any and all plan documents, claim-related documents and data, requested disclosures, complete insurance policy and health benefit plan documents, and/or settlement information, as necessary to secure benefits, reimbursement, or any remedies due and owed to me under my plan or policy.

I authorize the use of this signature on all insurance and/or employee health benefit claim submissions and permit a photocopy of my signature to be used to process such claims.

I further authorize the release and disclosure of my protected health information (PHI) under 45 C.F.R. §164.508, without limitation under the "minimum necessary" standard, to my authorized representative for the purpose of securing benefits due.

This authorization includes, but is not limited to, the authority to:

1. Obtain information or submit evidence regarding my claim to the same extent as I may do.
2. Make statements of fact or law in support of my claim.
3. Act as my authorized representative in connection with filing, receiving, and responding to any claim or appeal, including external review under applicable state or federal law; and
4. File for compliance assistance, penalties, or enforcement with the U.S. Department of Labor (DOL), the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), or any other governing agency overseeing health benefits and coverage.

This authorization shall remain valid until all claims, appeals, and remedies are fully exhausted and paid in compliance with applicable federal and state law, including but not limited to ERISA §104(b)(4), §503, and §502(c)(1).

I hereby assign and convey to Dove Family Clinic, Inc, to the fullest extent permissible under applicable law and under any insurance policy and/or employee health care plan, any claim, chose in action, or other right I may have with respect to insurance and/or employee health care benefits covering medical and/or mental health expenses incurred as a result of the services I received from the above-named Practice.

This assignment includes, but is not limited to, the right to claim and recover medical benefits, insurance reimbursement, statutory penalties, interest, attorney's fees, and any other remedies available under federal or state law, including but not limited to ERISA §§502(a)(1)(B), 502(a)(3), and 502(c)(1).

This authorization and assignment shall remain in full force and effect until all benefits and remedies are paid in compliance with applicable federal and state laws.

Further, in response to any reasonable request for cooperation, I agree to cooperate with Dove Family Clinic, Inc in any attempts to pursue any claim, chose in action, or right against my insurers and/or employee health care plan. Such cooperation may include, if necessary, signing documents or taking other actions to allow the Practice to bring suit in my name, but at the practice's sole expense, to enforce the collection of benefits, resolve disputes regarding my health care claims, and represent my interests in any proceedings related to the enforcement of plan benefits, including but not limited to arbitration, administrative hearings, or litigation.

Dove Family Clinic, Inc shall not undertake any actions beyond those expressly granted herein or required by law. The scope of this authorization is strictly limited to the collection of payments, enforcement of assigned benefits, release of medical and plan documents, and the initiation of legal or administrative action as necessary to secure payment and remedies under applicable federal and state law, including ERISA.

This authorization and assignment shall remain in effect until all benefits are paid in full compliance with applicable federal and state laws. It applies to all claims for services rendered in the past, present, and future, whether or not such claims have been submitted, denied, appealed, or remain outstanding at the time of this agreement.

Revocation of this assignment shall not apply retroactively to any claim or appeal submitted or initiated prior to the receipt of my written revocation. This authorization remains valid until revoked by me in writing, and such revocation shall not affect any action taken in reliance on this authorization before the Dove Family Clinic, Inc's receipt of written notice.

Unless revoked in writing, this assignment shall remain valid for all administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment shall be deemed as valid as the original.

By signing this form, I acknowledge that I have read and fully understand this agreement, and I hereby confirm (1) the appointment of my designated authorized representative, (2) the scope of that representative's authority, and (3) my right to revoke this appointment in writing.

I hereby designate and authorize Dove Family Clinic, Inc and/or its designated business associate, New Leaf Billing, Coding, and Auditing Solutions, LLC as my Authorized Representative under any and all plans including, but not limited to ERISA, Medicare, Medicaid, Tricare, applicable state law, and any similar federal or state provisions. This designation grants full authority to act wholly in my stead with respect to any and all claims, appeals, and disputes relating to my health benefits.

Such authority expressly includes, but is not limited to:

- Receiving and recovering all benefits afforded, due, or owed under my plan or policy.
- Taking any steps necessary to pursue administrative, internal, external, or judicial appeals.
- Exercising all rights of disclosure and remedies.
- Seeking governmental compliance assistance and pursuing any applicable causes of action.
- Requesting and obtaining all plan documents, claim files, investigative files, and other information to which I am entitled under federal or state law.
- Submitting evidence, making statements of fact or law, and signing documents as necessary; and
- Making all decisions necessary to protect and enforce my rights under my health plan, ERISA, HIPAA, the Mental Health Parity and Addiction Equity Act, the Affordable Care Act, and all other applicable federal and state laws.

I, the undersigned, hereby designate and authorize Dove Family Clinic, Inc and/or its designated representatives to act as my Authorized and Appointed Representative in all matters related to my health insurance benefits, including but not limited to Medicare (Parts A, B, C, and D), Medicare Advantage, Tricare, Medicaid, Managed Medicaid, ERISA-governed employee benefit plans, and all commercial or managed care health insurers. This appointment authorizes CMS, its contractors, and applicable review entities to release all necessary individually identifiable health information to my appointed representative as required to pursue claims and appeals.

This authorization further extends to Medicaid agencies, state Medicaid contractors, Tricare administrators, ERISA plan administrators, commercial insurers, and managed care organizations, and authorizes them to release all necessary benefit and claim information to my appointed representative as required by law.

This authorization includes, but is not limited to:

- Filing and pursuing all Medicare (Parts A, B, C, and D), Medicare Advantage, Medicaid, Managed Medicaid, Tricare, ERISA-governed, and commercial insurance claims.
- Requesting reconsiderations, redeterminations, grievances, compliance reviews, and hearings.
- Filing and pursuing appeals at all levels of the Medicare, Medicaid, Tricare, ERISA, or commercial appeal processes.
- Receiving all notices, disclosures, plan documents, and communications regarding my health insurance benefits and appeals related to my Medicare, Medicaid, Tricare, ERISA, or commercial health insurance benefits.
- Representing me in any administrative, regulatory, or judicial review related to my Medicare, Medicaid, Tricare, ERISA, or commercial health insurance benefits.

I understand that by signing this authorization, I am granting the above-named representative the legal right to act on my behalf in connection with all my health insurance benefits, including Medicare and Medicare Advantage benefits and appeals.

I further understand that:

- I may revoke this authorization at any time by providing written notice to Dove Family Clinic, Inc.
- Revocation will not affect any action already taken in reliance on this authorization prior to receipt of my written notice.
- This appointment will remain in effect until explicitly revoked in writing or until all claims, appeals, and related matters for services rendered by the above-named provider are fully resolved.

This appointment and acknowledgement shall apply to all federal and state health benefit programs, including but not limited to Medicare, Medicare Advantage (42 C.F.R. Part 422), Medicare Part D (42 C.F.R. Part 423), Tricare (32 C.F.R. §199.10), Medicaid, and Managed Medicaid organizations (42 C.F.R. Part 438). The Authorized Representative designation shall be accepted as valid and binding in accordance with all applicable federal and state laws, including but not limited to HIPAA (45 C.F.R. §164.508), ERISA, the Affordable Care Act, and the Mental Health Parity and Addiction Equity Act.

#### CMS-1500 Direct Payment Clarification

By signing this Assignment of Benefits, I acknowledge and agree that any claim submitted on a CMS-1500 form with Box 27 marked "Yes" authorizes direct payment of benefits to Dove Family Clinic, Inc. This authorization applies equally to Medicare, Medicare Advantage (Part C), Medicaid (including Managed Medicaid), Tricare, commercial insurance plans, and ERISA-governed employee benefit plans.

For Medicare, Box 27 authorizes payment directly to the provider but does not waive or alter any appeal rights under 42 C.F.R. Part 405 or the Medicare Secondary Payer Act. For Medicare Advantage (Part C), Box 27 authorizes payment directly to the provider but does not waive rights under 42 C.F.R. Part 422, nor does it obligate acceptance of reduced or contract rates absent a valid provider agreement. For Medicaid, including Managed Medicaid, Box 27 authorizes the state agency or its contracted MCO to pay the provider directly and does not waive any rights under state or federal Medicaid law. For Tricare, Box 27 authorizes direct payment as permitted under 32 C.F.R. §199.7 and does not obligate acceptance of reduced fees or waive appeal rights. For commercial and ERISA-governed health plans, Box 27 authorizes direct payment only; it does not constitute consent to accept discounted reimbursement, participation in a network, or waiver of appeal rights.

Box 27 represents direct payment = yes, waiver of appeal rights = no. All rights under ERISA, HIPAA, the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and all applicable state and federal laws are expressly preserved.

**Business Associate** — For purposes of this authorization and assignment, “Business Associate” has the same meaning as defined under 45 C.F.R. §160.103. A Business Associate is any person or entity, other than a member of the Provider’s workforce, who performs certain functions or activities on behalf of, or provides services to, the Provider that involve the use or disclosure of Protected Health Information (PHI). This includes, but is not limited to, attorneys, billing companies, claims advocacy firms, compliance consultants, and any other individual or entity engaged by the Provider pursuant to a Business Associate Agreement (BAA) to perform functions in compliance with HIPAA, the Affordable Care Act, ERISA, and applicable state privacy laws.

The patient and/or the patient’s authorized representative affirms that this authorization/consent is being given knowingly and voluntarily, without any element of force, fraud, deceit, duress, or coercion of any kind. The undersigned further affirms that he or she is physically and mentally competent to provide such authorization/consent, and that this consent is being provided on behalf of themselves, their minor child, or any person over whom they hold legal guardianship, as applicable.

I agree that this Assignment of Benefits and Release of Medical and Plan Documents form may be executed by electronic signature. I acknowledge and consent that my electronic signature shall carry the same legal force and effect as a handwritten signature for purposes of validity, enforceability, and admissibility. This agreement applies to myself, my minor child, or any person over whom I hold legal guardianship, as applicable.

I expressly acknowledge and agree that a photocopy, scanned image, facsimile, or electronically signed copy of this Assignment of Benefits shall be deemed legally valid, binding, and enforceable to the same extent as the original document.

All federal and state health benefit programs, plan sponsors, insurers, claims administrators, contractors, subcontractors, and third-party vendors are required to accept such copies without delay or denial of benefits, appeals, or enforcement rights.

This provision is intended to ensure full compliance with applicable federal and state laws, including but not limited to ERISA, HIPAA (45 C.F.R. §§164.502, 164.508), the Affordable Care Act, CMS regulations (42 C.F.R. Part 405), the Mental Health Parity and Addiction Equity Act, and all related consumer protection laws.

Any refusal to accept a valid photocopy or electronic copy of this authorization will be treated as a violation of my protected rights and may be subject to enforcement, penalties, and compliance action under the above laws.

By signing below, I acknowledge that I have read, understood, and fully accept the contents of this Assignment of Benefits and Release of Medical and Plan Documents. I certify that I am providing this authorization and consent freely and voluntarily, without coercion, and that it applies to myself, my minor child, or any person over whom I hold legal guardianship, as applicable.

Patient Signature and Date \_\_\_\_\_

\_\_\_\_\_

**OFFICE USE ONLY**

**Representative Acknowledgement**

I, the undersigned Authorized Representative, hereby accept the above appointment and agree to act in the best interest of the beneficiary/patient in accordance with the authority granted. I understand and acknowledge that this designation authorizes me to pursue claims and appeals at all levels; request, receive, or release medical and plan information as permitted by law; and take any action consistent with the patient's rights under federal and state law, including but not limited to Medicare, Medicaid, Tricare, ERISA, and commercial health insurance programs.

This appointment and acknowledgement shall serve as a legally valid substitute for CMS Form-1696 and shall be accepted by Medicare and its contractors under 42 C.F.R. §405.910; Medicaid and Managed Medicaid agencies under applicable state and federal regulations; Commercial and ERISA health plans as required under ERISA §503 and related provisions; and in accordance with HIPAA 45 C.F.R. §164.508 governing the release of Protected Health Information (PHI).

**Practice Signature and Date** *Darinda Dove FNP*

**Authorized Representative / Business Associate:**  
New Leaf Billing, Coding, and Auditing Solutions, LLC

# **Dove Family Clinic, Inc**

## **APPOINTMENTS, CANCELLATIONS & COMPLIANCE**

Please notify our office at least **24 hours in advance** if you need to cancel or reschedule your appointment. This allows us to offer the appointment time to another patient in need of care.

Patients who fail to provide at least 24 hours' notice for cancellations, rescheduling, or missed appointments without reasonable cause may be subject to a \$25.00 no-show fee, which will be collected at the next visit.

Copays are due at the time of service. Please be prepared to pay for services on the day of your scheduled appointment. A \$35.00 service fee will be charged for any returned checks due to insufficient funds or other banking issues.

Excessive missed appointments, repeated late cancellations, or repeated rescheduling may result in dismissal from the practice at the provider's discretion.

Name (print)\_\_\_\_\_ Date\_\_\_\_\_

Signature\_\_\_\_\_ Date\_\_\_\_\_