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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy practices and that I have (or had the opportunity to read if I so chose) and understood the notice.

Patient name (please print)

Date

Parent or Authorized representative (if applicable)

Signature

SIGNATURE ON FILE

- I authorize the doctor named above to use my name on any and all claims documents that relate to health insurance benefits due to me and my dependents.
- I authorize release of any information related to any claims to all my insurance companies or other relevant parties
- I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies
- I authorize payment of health benefits otherwise payable to me, directly to my doctor
- I permit copy of this authorization to be used in place of the original
- This "Signature on File" is valid for one year from the date indicated below

Signature of Patient, Guardian or personal representative

Medicare #
(if applicable)

Date

Please print name of Patient, Guardian or personal representative

Relationship to patient