



Dr. Hector Martinez  
Tri Modern Health  
110 W. Hillcrest Blvd. Suite 103  
Schaumburg, IL 60195  
P: 847-884-8488

**Insurance and Assignment of Benefits:**

I understand and agree that health/accident insurance policies are an arrangement between and insurance carrier and myself. I understand that I am ultimately responsible for all charges associated with my healthcare. For my convenience Tri Modern Health have been given a quote of benefits from my insurance company, which is not binding. The exact services provided each visit will reflect my clinical needs that day. I understand that I am personally responsible for any service specified as non-covered or bundled (e.g. exam codes such as 99202-99204, 99212-99214 or Therapy codes such as 97140, 97035, 97032, Acupuncture) by my insurance company and agree to pay for the services rendered. By signing this I am giving permission for Tri Modern Health to submit claims on my behalf. After the explanation of benefits is received from my insurance company, I will be billed for the remaining balance or will receive a refund, if applicable.

**Notice of Privacy Practices Pursuant to HIPPA and Consent for use of Health Information:**

\_\_\_\_\_, hereby states that by signing this Consent, I acknowledge and agree as follows:

The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

.I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Patient Name (Please Print): \_\_\_\_\_

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

Guardian’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_