NOTICE and ACKNOWLEDGEMENT

Acknowledgement:

1. I authorize Ed Fahey Associates, P.C. to release information from my medical records to third-party insurers or their representatives, as is necessary to receive reimbursement for any billings rendered relating to my treatment. These insurance carriers include, but are not limited to, Medicare, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers disability compensation insurers and managed-care plans, which may be responsible for payment in my case, or as required by law.

2. I understand that deductible, co-payment and/or co-insurance portions may be assigned as my responsibility as determined by my insurance provider. I understand my insurance company will notify me by mail explaining my benefits regarding individual treatment sessions. As I receive them I will promptly respond to the receptionist at Ed Fahey Associates for clarification as needed. I assume full financial responsibility for payment of all patient portions as finally determined by my insurance company and DLC, the off-site billing service contracted by Ed Fahey Associates. I will also give full assistance to both Ed Fahey Associates DLC in obtaining the collection of the insurance company portion.

3. I understand the content and significance of this form and my questions have been answered.

4. I have received a copy of the office notice of privacy practices (HIPAA) and I understand its contents. (Copy available upon request.)

_____ _____

Patient's Name (please print) **Date:**

_____

Signature of Patient / Patient Representative and relationship