Patient Name________________________________(Print)Date of Birth_________

AUTHORIZATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare and/or Insurer benefits be made on my behalf to Drs. Egoville, Finkenstadt, Rosenberg, Breen and Valentino or Penn Jersey Pulmonary Associates for any services furnished me by these physicians. I understand that I am financially responsible for all charges incurred for services rendered as recipient of same regardless of insurance coverage. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine the benefits or the benefits payable to related services.

SIGNATURE__________________________________DATE_________

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NOTICE OF PRIVACY PRACTICES (HIPPA) Acknowledgement

I acknowledge that I understand the Notice of Privacy Practice of Penn Jersey Pulmonary Associates (posted) written in plain language. The notice provides in detail the use and disclosure 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. **I am entitled to an individual copy of the notice at any time.** 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 controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

SIGNATURE________________________________DATE_________

Relationship to patient (if signed by a personal representative of patient)_____________