HIPPA CONSENT FOR USE OR DISCLOSURE OF INFORMATION FOR PURPOSES REQUIRED BY THE OFFICE OF **SCOTT RIGDEN, M.D.**

I hereby permit the office of Scott Rigden, M.D. to use my health information, and/or to disclose my health information to any third party payor, or to any party involved in my health care.

I understand that there is a Notice of Privacy Practices posted in the office available for me to read.

This consent shall be in force and effect as long as I am a patient in this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my doctor at this practice.

I understand that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this consent form.

____

Signature of patient or patient representative Date

____

Printed name of patient or patient representative

NON COVERED SERVICES WAIVER

NON-CONTRACTED INSURANCE PATIENTS ONLY

I have been informed and understand that the service I will receive pertaining to weight loss will not be submitted to my insurance carrier by Dr. Rigden's office. I also understand that I am personally and fully responsible for all payments.

ACCEPTED INSURANCE PATIENTS

I have been informed that some services pertaining to weight loss may **NOT** be covered by my insurance carrier (examples may be: body fat percentage test, nutritional counseling). I understand I will be personally and fully responsible for all payment to Dr. Rigden for charges after my insurance has been billed and deemed not covered or not medically necessary.

PATIENT NAME: ____

PATIENT SIGNATURE: ____

DATE: ____