DOUGLAS W. HOLTE, M.D.
BROKEN ARROW FAMILY PRACTICE CENTER

NOTICE OF PRIVACY PRATICES / FINANCIAL AGREEMENT

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy at our front desk.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to evoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By signing below, you verify the above information to be true and correct. You understand that you are responsible for all charges at the time services are rendered unless prior payment arrangements have been made.

Your signature below authorizes your insurance company to make payment of medical benefits to Douglas W. Holte, M.D. on your behalf for medical services rendered. You agree to pay promptly any balance outstanding after insurance payment or denial of benefits. You understand you are financially responsible for payment of services regardless of insurance status and expected benefits. A photocopy of this signature is as valid as the original.

Patient Name:
(Please Print:_____ Patient Date of Birth:_____

Signature: _____ _____
Patient / Guarantor's Signature Date

PRIMARY CONTACT

Please indicate a family member(s) or other person(s) with whom we may discuss your health-related issues if anyone.

Name: _____ Relationship to Patient:_____

Home Phone:_____ Work Phone:_____

Name: _____ Relationship to Patient:_____

Home Phone:_____ Work Phone:_____

ADVANCE DIRECTIVE

Your signature below indicates that you have been given information on the "Advance Directive for Health Care (Living Will)".

Signature:_____ Date:_____