MD WEST | ONE
ORTHO • NEURO • EXCELLENCE

****Third Party Payor Agreement****
I hereby authorize MD West ONE, P.C., to furnish third party payors with any information concerning the medical care, treatment, and billings. I hereby assign to MD West ONE, P.C., all payments for medical services to be rendered to me or my dependents, and I authorize direct payment for such benefits to MD West ONE, P.C., by any third party payor. I also agree that if any dispute arises between MD West ONE, P.C., and me, the laws of the State of Nebraska shall govern, and all disputes between MD West ONE, P.C., and me must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

Release of Health Information I authorize MD West ONE, P.C., to release my health & billing information to:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Appointment Reminders I authorize MD West ONE, P.C., in the event I am unreachable to leave a message regarding my appointment time, changes or scheduling information on my answering machine, voicemail or with the person answering the phone.

Preferred Method of contact for appointment reminders or changes ☐Phone ☐Text ☐Email

Policy Notice Receipt of Acknowledgement (initial each)

_____ I acknowledge that I was offered a copy of the Notice of Privacy Practices.

_____ I acknowledge that I was offered a copy and agree with the terms of the Financial Policy

_____ _____
Signature of patient or authorized legal guardian/agent Date

_____
Print Name