

**Todd W. Ulmer, MD, PC**  
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**(503)253-1223**

**ASSIGNMENT OF BENEFITS**

**1. AUTHORIZATION FOR INSURANCE OR PAYMENT/FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits to Todd W. Ulmer, MD, PC. I am financially responsible for all services provided by Todd W. Ulmer, MD, PC, to me or my dependents. If Todd W. Ulmer, MD, PC, is not a participating provider in my insurance plan, I understand that payment is required at the time of service. If my insurance requires a referral from my primary care physician, I will provide the referral and authorization at time of service. I understand that I am financially responsible for any and all charges not covered by my insurance company. I understand co-pays are due at the time of service along with any deductibles or non-covered services.

**2. ACKNOWLEDGEMENT AND CONSENT**

A **NOTICES OF PRIVACY PRACTICES** is provided to all patients on their first visit. This Notice of Privacy Practices identifies how medical information about you may be used or disclosed. It explains your rights to access your medical information, to request an accounting of disclosures of your medical information, and to request additional restrictions on uses and disclosures of that information. It explains your right to complain if you believe your privacy rights have been violated, and our responsibilities not only to maintain the privacy of your medical information but also to let you know if your privacy is breached.

Acknowledged and agreed:

Name of Patient (print):

Signature:

Date: