



**Pamela L. Vincent MD, P.C.
Riverwoods Neurological Center**

Assignment of Benefits / Medical Release / Consent for Treatment

I hereby consent to any medical treatment, x-ray, laboratory or other procedure, which the physician (s) may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due me to be paid directly to Pamela L. Vincent MD, P.C., 280 West River Park Drive Suite 350 Provo, Utah 84604. This agreement will remain in effect until I choose to revoke it in writing.

PATIENT'S
SIGNATURE: _____ DATE _____

***Medicare Patient Agreement
(Required by Medicare for all Medicare claims)***

Patient's Name:

Medicare Subscriber Number:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pamela L. Vincent MD, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to be released to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

PATIENT'S
SIGNATURE: _____ DATE _____

Receipt of Notice of Privacy Practices – Written Acknowledgement Form

I, _____, have received a copy of Pamela L. Vincent MD

P.C.'s Notice of Privacy Practices

PATIENT'S
SIGNATURE: _____ DATE _____