DAKOTA VASCULAR
Complete Vascular Care

Financial Responsibility, Payment and Collection, Privacy Practice and HIPAA Policy Consents

I, _____ (Patient Name) and _____ (Date of Birth)

By signing below, I confirm that I have read, understood, and agree to adhere to Dakota Vascular's Financial Responsibility, Payment and Collections Policy, and Notice of Privacy Practices and HIPAA Consent.

By signing below, I hereby authorize Dakota Vascular to file claims on my behalf to my insurance company (or companies), and I agree that payment from my insurance company (or companies) is to be made directly to Dakota Vascular.

1. **Financial Responsibility and Payment and Collection Policy**
2. **Notice of Privacy Practices and HIPAA Consent**

I understand that this consent shall remain in force from this time forward.

Signature: _____

Date: _____

If Individual is unable to sign, please complete the information below:

Relationship of Signer: _____

I _____ (Patient Name) consent that the following individuals may receive information regarding my medical care and treatment, appointment information, and billing information.

Name: _____ Relationship:_____

Name: _____ Relationship:_____