DuPage Medical Group is now:

duly HEALTH AND CARE

Patient Label

MRN: _____

Pt Name: _____

Date of Birth: _____

Do Not Bill Insurance (Patient Requested Restriction)

You have the right to request restrictions as to how your protected health information (PHI) may be used and/or disclosed to carry out payment. Duly Health and Care (Duly) has the right to deny your request under certain circumstances. **You will be asked to pay the amount in full at the time of service.** To exercise your right to request a restriction on the disclosure of your PHI, please complete the fields below:

Patient Information

Patient Name: _____

Date of Birth: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Please do NOT share the health information specified below with my health insurance company.

(If fields are left blank, charges will be billed to insurance.)

Date of Service:	Type(s) of service (office visit, lab, imaging, etc.):	Provider Name:

With the signature below, I understand I am exercising my patient right under HIPAA. I acknowledge Duly will be unable to honor my request if:

- Services have already been rendered and information has already been released to my health insurance
- Services are to be paid by a third-party liability (TPL) insurance
- My request is made for an elective procedure I know will not be covered by my insurance
- My request is made for services related to a motor vehicle accident (MVA)
- I have not paid my balance related to this request in full within 30 days from the date of service. **After 30 days without payment, my information will be released to my health insurance company so Duly may be reimbursed accordingly.**

_____ _____

Signature of Patient or Legal Representative **Date**

Relationship to Patient: _____

_____ _____

Witness Signature & Printed Name Date