PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that my insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the Insured or his/her family.

RELEASE OF INFORMATION: The physician(s)may disclose all or part of the patient's record to any person or corporation which may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all parts or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (H.M.O.). Subsequent rejection of a claim as a result of this admission, due to the current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION- PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or it intermediary carriers, any information needed for this, or related, Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Verification of Non-Pregnancy:
Date:_____ File #_____
Date of L.M.P_____

By my signature on this form I do hereby state that to the best of my knowledge I am not pregnant, nor is pregnancy suspected at this particular time.

X_____
Print Patient's Name

X_____
Patient's Signature

X_____
Other than patient, print name & relationship

X_____
Witness

Financial Policy

Please have your insurance ready on the day of your visit.

Out of Network Payments: Our office is out of network with most insurance companies. If your insurance has out of network benefits, you insurance may be sending you the payments for your visit. You are solely responsible for payments and agree to forward any and all payments to our office immediately.

Self-Pay: If you do not have a health insurance or if your health insurance will not pay for services, you will be considered a self-pay patient. Our office will provide an affordable payment option upon your visit or once we are able to verify your insurance. Kindly make the full payments on your visit. We accept Cash, Checks, and Credit card.

Deductible: The annual amount you pay for covered health care services before your insurance contributes to your medical bills.

Copay: A fixed amount you pay for a covered health care service after you've paid your deductible.

I _____, have acknowledged that I have read and
Print name
understood the above statement.

_____ _____

Patient Print name **Date**

_____

Patient Signature

(Guardian must sign for patients under 18)

RECORD RELEASE AUTHORIZATION

DOCTOR/HOSPITAL _____

ADDRESS_____

_____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

_____ _____

Patient's Signature **Date**

_____

Patient's Name- Please Print

_____ _____

If Patient Is a Minor, Signature Of Parent or Legal Guardian **Relationship to Patient**

_____ _____

Witness to the above Signatures **Witness Please Print Name**