CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and/or surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other service rendered the patient under the general and special instructions of the patient's physician. ___________(initials)

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION** In consideration of services render, I hereby transfer and assign to my physician all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The physician may disclose all or any part of the patient's record, including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the physician's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. __________(initials)

3. **FINANCIAL AGREEMENT** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of service to be rendered to the patient, he/she obligates himself/herself to pay the account of the physician in accordance with the regular rates and terms of the office. Should the account be referred for collection, the undersigned should pay reasonable collection expenses and fees. The undersigned certifies that he/she has read for foregoing and received a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts it terms. __________ (initials)

4. **MEDICARE/MEDICAID** Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medical claim. I hereby certify all insurance payment pertaining to treatment by this physician shall be assigned to said physician treating me. ___________ (initials)

5. **USE OF COPIES** I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at this office. __________ (initials)

6. **PAYMENT RESPONSIBILITY** I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for service rendered to the physician. Some companies pay fixed allowance for certain procedures and others pay a percentage of the charges. I understand it is my responsibility to pay any COPAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCES NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME. __________(initials)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have received a copy of the Notice of Privacy Practice and I have a copy of the notice or may obtain one at any time.

Patient/Legal Representive:______________________________ Witness:____________________

Patient refused to sign this acknowledgment: Reason: ______________________________

DATE: __________ PATIENT'S SIGNATURE: ______________________________

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