Consent for Treatment

I voluntarily agree and consent to authorize the administration and performance of all medical diagnostic and treatment procedures during my visit to the Practice, I authorize my doctor, the Practice, and its employees, students in health care training programs, and all other persons caring for me to diagnose and treat me in ways they judge are beneficial to me. I fully understand and recognize that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees whatsoever have been made to me relative to the result(s) of examinations or treatments. I agree to allow recordings and photographs of me to be made by employees, agents, contractors, and doctors of the Practice for reasons including, but not limited to, assistance in diagnosis/treatment, teaching, research, documentation of conditions present, and physican internal purposes.

_____ _____

Patient Signature Date

The patient is unable to consent because _____.

I, therefore, consent on behalf of the patient:

_____ _____ _____ _____

Signature Relationship to Patient Witness Date

Consent for Review and Release of Information for Claim Determination, Payment, and other Purposes

The Practice often uses parties not related to it to perform a variety of tasks and services. The Practice contracts with such third parties to facilitate tasks as billing and collection of fees for services provided to patients.I (as the patient or as agent of the patient) understand the above and authorize the Practice to allow access to and/or release information contained in my medical record to third parties engaged by the Practice for the above services and others of a similar nature. This authorization includes release of information concerning diagnosis and treatment of drug and/or alcohol abuse, drug related conditions, alcoholism, psychological conditions, and/or HIV related conditions.Many third party payors, employers, and government agencies are requesting private (not affiliated the Practice) agencies to review the medical care and medical records of our patients. Failure to consent to such a review or revocation of this consent may make the patient personally responsible for all charges incurred. The insured's employer may be participating in such review activities, and details of treatment may be reviewed by the insured's employer or their agent.Federal law requires the Practice to inform you that if Medicare pays for any part of your health care bill, your medical record may be reviewed by a review organization. This review is to assure the government that services are medically necessary and meet recognized standards of quality. Redisclosure of any of the above information requires separate written authorization. This authorization will expire upon receipt of final payment except where allowed by law or upon revocation of this release.I (as the patient or as agent of the patient) understand and authorize the Practice to allow access to and/or release medical information, including copies of such information, to the Centers for Medicare and Medicaid Services and any other third parties applicable to the services rendered for the purposes of reviewing, establishing, or verifying eligibility for physician benefits and for the billing of physician services. This authorization includes release of information concerning diagnosis and/or treatment of drug and/or alcohol abuse, drug related conditions, alcoholism, psychological conditions, and/or HIV related conditions.I understand that the above authorization applies to all records and accounts generated and services rendered while a patient of the Practice.

_____ _____

Signature Date

Consent for Claim Payment

The Practice will initiate payment of your claims for benefits. In order to do this, it is necessary for all responsible parties to give the Practice certain rights and permission. All patients are responsible to have knowledge of their insurance requirements and to convey the applicable requirements to the Practice. I (as the patient or as agent of the patient) assign and transfer all rights of third party payor benefits for services rendered to me to the Practice and authorize any and all third party payments to be made directly to the Practice.I certify that the information given by me in applying for payment under the Social Security Act, or under the terms of any other payor is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment. I assign the benefits payable for covered Medicare services performed, and any other services performed, to the Practice and authorize the Practice to submit a claim to Medicare or other third party payor for payment. Any assignment of benefits is limited to the Medicare allowed charge for physician services or to an amount not to exceed the Practice's customary charges. I understand that, in consideration of the services to be rendered, I may be responsible for payment for any services not covered by third party payors and I will pay any and all charges due and owing the Practice at its customary rates and according to its terms and policies. I understand that the above authorization applies to all accounts generated and services rendered while a patient of the Practice.

_____ _____

Signature Date