

**Ebb Tide Comprehensive Care**

**Consent for Treatment, Assignment of Benefits, Release & Financial Policy**

Thank you for choosing Ebb Tide Comprehensive Care to meet your medical needs. We provide the best treatment available. **Carefully read and initial each section and sign and date the bottom.**

**Patient Consent for Treatment**

I voluntarily consent to all health care treatment and diagnostic procedures provided by Ebb Tide Comprehensive Care and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further stat that I understand that no guarantee has been or can be made as the result of treatments or examinations by Ebb Tide Comprehensive Care.

**Initials \_\_\_\_\_\_\_\_**

**Assignment of Benefits & Release of Information**

I hereby authorize treatment of myself, or the minor described above. I hereby authorize Ebb Tide Comprehensive Care to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary for Ebb Tide Comprehensive to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.

I authorize Ebb Tide Comprehensive Care to obtain all my medication/prescription history when using an electronic system to prescribe medication. I acknowledge that I retain the right to review Ebb Tide Comprehensive Notice of Privacy Practices in the office upon request.

**Initials \_\_\_\_\_\_\_\_**

**Financial Policy**

**Missed Appointments:** A Missed Appointment fee of $ 50.00 may be charged if you do not show up for a scheduled appointment or cancel with less than 24-hour notice. This fee must be paid before a new appointment is scheduled. You may be discharged from Ebb Tide Comprehensive Care if you have more than 3 missed appointments.

**Initials \_\_\_\_\_\_\_\_**

**Account Balances:** Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until payment arrangements have been established. If you have failed to make appropriate payment arrangements after 2 billing statements, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to meet agreed upon terms, your account may be turned over to an outside collection agency. Accounts assigned to Collections may be charged a $ 50 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative care. During that 30-Day period, our physicians will only be able to treat you on an emergency basis.

**Initials \_\_\_\_\_\_\_\_**

**Insurance:** Ebb Tide Comprehensive Care participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate in your plan and the physician you will be seeing is in network with them. **A Valid Driver’s License** and **Insurance Cards must be presented** at each visit. If you do not have your up-to-date insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay.

**Initials \_\_\_\_\_\_\_**

**Self-Pay patients and patients who have not met their deductible** are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all the services you receive may be non-covered by Medicare or other Insurers. You are responsible for all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of the visit.

**Co-Pays must be paid Prior to services being rendered.** Your Insurance Company may deny the claim if co-pays are not collected, and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will reschedule your appointment. **Deductibles and co-insurance fees must be paid at check-out.** Patients who are unable to pay for the services are required by their insurance will be required to speak with an account representative to set up a payment plan.

**Initials \_\_\_\_\_\_\_**

**Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Employee Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**