WEST TEXAS DEVELOPMENTAL PEDIATRIC & BEHAVIORAL HEALTH NETWORK, P.A.

3301 101ST Street
Lubbock, Texas 79423
(806) 281-9966

AUTHORIZATION AND AGREEMENT FOR TREATMENT

The undersigned hereby makes the following Acknowledgments and Agreements regarding treatment to be provided to the patient whose name appears below.

1. **Consent to Treatment.** I understand that medical treatment is necessary, and that such medical treatment will be performed by independent physicians, and or by the employees of the Practice. I hereby grant my authorization and consent for such treatment.
2. **Agreement to Pay for Services**. I acknowledge and accept that no guarantee has been given as to the results these treatments may produce in me. I further acknowledge and accept that any treatment(s) given may not help me and may make my condition worse. For and in consideration of the care and treatment provided to myself, I promise to pay, or arrange for payment, **AT THE TIME OF THE VISIT** all charges due for services rendered to or on behalf of the patient. Payment may be made by cash, check or credit card. Legal action to collect money from insufficient fund checks or stop payment checks; will be at the patient's expense. In the event your account is turned over to a collection agency, a 40% fee will be added to the balance. Any fees associated with the collection of a past due balance will be the responsibility of the patient.
3. **Assignment and Instruction for Direct Payment to Doctor**. I hereby instruct and direct the ___________________________ Insurance Company to issue payment directly to:

West Texas Developmental Pediatric & Behavioral Health Network, P.A.
P.O. Box 54136
Lubbock, Texas 79453

If my current policy prohibits direct payment to medical practitioners, then I also instruct and direct you to issue the payment in my name and mail it directly to:

West Texas Developmental Pediatric & Behavioral Health Network, P.A.
P.O. Box 54136
Lubbock, Texas 79453

For the professional and medical benefits and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY.** This payment will not exceed my indebtedness to the above named assignee(s).

Also, I have agreed to pay, in a current manner, the balance due of any and all professional and medical service charges over and above any insurance payment. I understand that **I am fully financially responsible for all these charges at all times**.

4. **Release of Medical Information**. I authorize the release of any and all information pertinent to my case to any insurance company, adjuster, or attorney involved in this case who makes the request in writing. Further, I authorize the release of my medical information to my personal or referral physician.
5. **Risks**. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of any medical, and/or diagnostic procedures planned for me. I realize that common to a medical, and/or diagnostic procedure is the potential for infection, allergic reactions, failure of treatment, and even death.
6. **Cancellation Charge**. **A $25.00 fee will be charged to the patient for all appointments not cancelled 24 hours prior to the appointment. Insurance companies including Medicare will not pay for this charge; therefore the patient will be 100% responsible for the fee. In the event you fail to cancel 2 (two) appointments you will be dismissed from the practice.**
7. **Health Information Exchange.** I authorize my provider(s) to e-prescribe my prescriptions and request my prescription medication history from other healthcare providers or third-party pharmacy payors. I understand that this means my provider(s) may send or receive my prescription electronically. My medical records will also be made available to other healthcare providers through a Health Information Exchange (HIE) or shared electronic medical record (EMR) with participants in UMC's clinically integrated network. I may opt out of participating in the HIE by completing an opt-out form at registration.

I have read the above Acknowledgments and Agreements, and fully understand and agree to them.

Dated at the **Office of West Texas Developmental Pediatric & Behavioral Health Network, P.A** .

This ____________________________ day of __________________________________, 20 _________.

Patient Signature ____ Witness Signature ______________________________

Policyholder Signature, if other than Patient ____

A photocopy of this form shall be conceded as acceptable and valid as the original.