

CONSENT TO TREATMENT AND FINANCIAL ASSIGNMENT/RESPONSIBILITY Clark Physician Group

I. PERMISSION FOR ADMISSION AND TREATMENT

Permission is hereby granted to Clark Physician Group to render such medical examinations, treatments, and procedures as are considered advisable by my physician for my health and well-being.

I understand that each patient has the right to consent or refuse consent to any proposed procedure or treatment and that no patient will be involved in any research or experimental procedure without his or her knowledge and written consent.

II. AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I authorize Clark Physician Group to release and/or obtain information from my medical record, or permit inspection of such medical information, including but not limited to psychological/psychiatric, drug/alcohol related conditions, communicable disease diagnosis, and/or testing including the results for Human Immunodeficiency Virus Infection (HIV), Hepatitis, or other blood-borne infectious disease for the purpose of treatment, payment, or health care operations as more fully described in *The Notice of Privacy Practices*.

I understand that certain information may be released to the Health Department officials responsible for control of infectious diseases in accordance with the requirements of federal, state, and local laws and regulations.

III. FINANCIAL RESPONSIBILITY

Assignment of Insurance Benefits

As a courtesy, a claim will be submitted to the insurance provided for the services rendered. I hereby authorize payment of my insurance benefits (otherwise payable to me) directly to physicians, but not to exceed the balance due of the regular charges for this date of service. I understand that I am financially responsible to Clark Physician Group for charges not covered by this authorization including deductibles and/or co-insurance amounts.

IV. GUARANTEE OF ACCOUNT

The undersigned hereby agrees to pay the provider(s) for services rendered during my physician visits. I understand patient monies received by the Clark Physician Group will be applied to any of my accounts with an outstanding balance.

I understand and agree that if I fail to make any of the payments that I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney, I will be responsible for all monies including court costs, collection agency, and/or attorney fees.

V. MEDICARE & MEDICAID/CHAMPUS & CHAMPVA PATIENTS

I certify that the information given by me in applying for payment is correct. I authorize the release of medical and related information about my treatment to the Social Security Administration, including its intermediaries or carriers, to both the contractor and the government, and to the Peer Review Organization responsible for reviewing the medical care furnished me by your institution only such information needed for this or a related claim. I further authorize the Social Security Administration to release to Clark Physician Group any information which they maintain in regards to the extent of my coverage under Title XVIII and Title XIX of the Social Security Act.

- I do not have Medicare
- I do not have Medicare Part A
- I do not have Medicare Part B

Medicare Primary/Secondary Determination

I (patient) acknowledge(s) that to the best of my (patient) ability, I (patient) have answered the appropriate questions to determine if Medicare is primary or secondary payor for this claim.

_____ Patient's Initials

I hereby authorize the following person(s) to obtain medical information about me, i.e., tests results, outcomes, diagnosis, etc.

1. _____
2. _____
3. _____
4. _____
5. _____

_____ Patient's Initials

I acknowledge that I have received a copy of the *The Notice of Privacy Practices* (effective 4/14/03).

_____ Patient's Initials

I acknowledge I have received information that describes my patient rights and responsibilities as well as my rights under state law to make decisions concerning my medical care.

Patient Signature

Date

Witness Signature

Date

Signature of Guarantor, Legal Guardian, or Closest Relative Relationship

Patient is: _____ a minor, _____ years of age or, _____ unable to sign