Patient Name: _____DOB:_____

AUTHORIZATION TO TREAT

I understand that this authorization includes my consent for medical tests, procedures, drugs and other services and supplies as considered advisable. This treatment may include, but is not necessarily limited to, anesthesia, pathology, radiology and other imaging and diagnostic services, and other special tests and services including tests for communicable diseases and toxins, as ordered by the physician responsible for my care during my visit. I acknowledge that the practice of medicine is not an exact science and no guarantees or promises have been made to me as to the results of examination, care, or treatment. I acknowledge that it is important for me to provide accurate and complete information regarding my symptoms, medications, drug use, and other information, and that failure to do so can adversely impact my care.

I request that payment authorized by my insurance company, the Center for Medicare and Medicaid Services, or its carriers, be made on my behalf for services provided. I certify that any information I provide related to my eligibility for coverage or payment is accurate and complete. I understand that notification of I am required to any change in my coverage is my responsibility. I understand I am financially responsible for payment of services provided during this visit if I do not have insurance coverage or if I have coverage and timely payment is not made. I also understand that if I have a co-payment for this service, it is payable today. I may be charged an additional fee to cover the cost of billing the co-payment, if not paid today. I understand that I am responsible for paying the amount of any discount imposed by my insurance provider or third party payer imposes discounts.

Some insurance companies require pre-authorization services. If I am required to obtain an authorization for today's visit and have not done so, I agree to assume all financial responsibility. If I receive any additional services from specialists, hospitals, or other healthcare providers in connection with, or as a result of this visit, those charges may also be my responsibility, unless preauthorized as required by my insurance company. I authorize the release of medical or other information to my insurance company, the Center for Medicare and Medicaid Services, or its carriers as necessary to determine payment for these or related services. Certain lab tests may be sent to an independent lab for processing. I understand I may receive a separate bill for these services. In the event that collection procedures are initiated on any outstanding balance, I agree to be responsible for the costs of collection including, but not limited to: court costs, expenses, and attorney fees, to the extent permitted by law. I understand that the foregoing provision applies equally to myself or any individual for whom I am authorizing treatment.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge a copy of the Notice of Privacy Practices has been provided to me to review outlining my Personal Health Information (PHI) and how that information is used.

Patient or Representative Signature _____

Date_____