

CONSENT FORM

1 Financial agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

Patient Name _____
 Signature of responsible party _____
 Today's Date _____

2 Consent for minor

I grant the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature _____ Date _____
 Relationship to patient _____

3 Notice of privacy practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

Signature _____ Date _____

If not signed by the patient, please indicate the relationship between the signee and the patient:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

For office use only

Date received _____ Copayment _____
 Authorization required Yes No Processed by _____
 Practice follow-up Yes No Date of follow-up _____

Complete the following only if the patient refuses to sign the acknowledgement
 Efforts to obtain _____
 Reason for refusal _____
