Consent and Policy Agreement

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MEDICAL CONSENT: My care as a patient is directed by a licensed physician. I consent to services rendered and provided to me.

CONSENT FOR RELEASE OF INFORMATION:

Release of Information to Physician, Referring Physician, Insurer, and Professional Review Organization: I authorize release of medical and related information, including alcohol, drug abuse, and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carrier, if applicable, for the purpose of obtaining care, treatment, or payment for services provided or to be provided. This information may be released via first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

Social Security Numbers: Social Security Numbers are NOT collected. If given, it is for the purpose of patient identification, compliance with federal and state agency reporting requirements, and billing to insurance carriers and collection needs. Disclosure of the social security number information is *voluntary*. If I have provided this information, then authorize release for the purpose stated above.

STATEMENT OF FINANCIAL RESPONSIBILITY

Financial Agreement: The undersigned, jointly and separately, in consideration of services to be rendered to patient, agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. The undersigned assigns to each provider of service all insurance benefits available for the professional and clinic services rendered. The assignment is irrevocable, and the undersigned authorizes carrier of said benefits to make payment directly to their practitioner or other related billing services. Payments received from insurers will apply to the patient's account balance obligation. The undersigned agrees to promptly pay any charges that are not immediately **(within 30 days)** covered by insurance. Quoted benefits and/or payment from insurance companies are not a guarantee of coverage. ***It is the responsibility of the insured to verify benefits and coverage from their insurance company PRIOR to services rendered.***

FINANCIAL POLICY

I have reviewed and agree to the Financial Policy terms. **Initials** _____

HIPAA PRIVACY POLICY

I have been given the opportunity to review the "HIPAA" privacy policy. **Initials** _____

EMAIL POLICY

I understand that email is not secure for Personal Health Information (PHI) exchange and acknowledge that any emails sent to and from my provider are not protected under HIPAA. Providers do NOT initiate new email exchange, but can reply if initiated. Patient Ally is secure for PHI exchange. **Initials** _____

- **Email Address:** _____

I agree to the above consents, authorizations to release information, financial agreement, and HIPAA privacy policies that apply to the medical services provided for TWO (2) YEARS from the date shown below.
I have read, fully understand, and agree to the above statements.

Patient Signature | Patient PRINTED name | Date

Parent, Guardian, Responsible Party, Legal Representative SIGNATURE/PRINTED NAME | Date