

**AUTHORIZATION, CONSENT AND GENERAL RELEASE**

**AFFIRMATION & ASSIGNMENT:**

I authorize my insurance benefits to be paid directly to the physician/clinic entity. I understand that I am financially responsible for any balance. I also authorize The Clinic of Gadsden PC and/or my Insurance company to release any information required to process my claims.

**AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:**

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments, the patient is responsible for all fees regardless of insurance coverage. It is customary to pay for the services when rendered unless other arrangements have been made in advance. All copays are payable at the time of service.

I hereby authorize The Clinic of Gadsden PC to furnish the insurance companies, or their representatives, information concerning my (or my dependents) illness and treatments and I hereby assign to The Clinic of Gadsden PC all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize and release the doctor and whomever he/she may designate as her/his assistant to administer treatment, perform physical exams, x-ray studies, laboratory procedures, perform medical care or any clinical service that he/she deems necessary in my case, and I further authorize him/her to disclose all or part of my (patient’s) record to any person or corporation entity which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic charge, including but not limited to hospital or medical services company, insurance company, workers compensation carriers, welfare funds, or the patients employer.

**PATIENT INFORMATION CONSENT:**

I understand that The Clinic of Gadsden PC may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting or referring my treatment; for obtaining payment for services, and for the purpose of operating the practice. I consent to the use of my information for the purpose of treatment, payment and general healthcare operations.

I understand that my consent is not needed if the Law requires The Clinic of Gadsden PC to report some aspect of my Protected Health Information (PHI) to a government agency (for example, suspected abuse, communicable disease and potential bodily harm to myself or others).

I understand that I have the right to review The Clinic of Gadsden PC’s privacy notice to request restrictions be put on the use of my information, and revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operations, The Clinic of Gadsden PC may refuse to undertake my care.



**AUTHORIZATION, CONSENT AND GENERAL RELEASE (Page Two)**

I, the undersigned, hereby consent to the following treatment: Administration and performance of all treatments, administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary advisable based on the judgement of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent will remain in full force until revoked in writing. I understand that The Clinic of Gadsden PC may include consent at satellite offices under common ownership and control.

**MEDICARE PATIENTS:**

I authorize to release medical information about me to the social security administration, Centers for Medicare and Medicaid Services (CMS) or it’s intermediaries, for my Medicare claims. I assign the benefits payable for services to The Clinic of Gadsden PC.

**HIPPA ACKNOWLEDGEMENT:**

I have received and read The Clinic of Gadsden PCs Notice of Privacy Practices. In my absence, or for the benefit of gaining medical advice on my behalf, I authorize the following person(s) to gain Protected Health Information (PHI) for or with me:

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(Please list authorized Representatives(s) or mark N/A)

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO TIS CONTENT. ALSO, THAT ALL INFORMATION PROVIDED IS TRUE, CORRECT AND ACCURATE TO MY KNOWLEDGE.

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Patient/Guardian Signature Date