

STONECREST FAMILY PHYSICIANS

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. \_\_\_\_\_ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, STONECREST FAMILY PHYSICIANS may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. \_\_\_\_\_ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that STONECREST FAMILY PHYSICIANS may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. \_\_\_\_\_ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to STONECREST FAMILY PHYSICIANS any insurance or other third-party benefits available for health care services provided to me. I understand STONECREST FAMILY PHYSICIANS has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to STONECREST FAMILY PHYSICIANS, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. \_\_\_\_\_ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to STONECREST FAMILY PHYSICIANS by the Medicare or Medicaid program.

5. \_\_\_\_\_ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for STONECREST FAMILY PHYSICIANS, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that STONECREST FAMILY PHYSICIANS or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or STONECREST FAMILY PHYSICIANS or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. \_\_\_\_\_ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X \_\_\_\_\_ Date \_\_\_\_\_

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- |                |                              |
|----------------|------------------------------|
| Spouse         | Guarantor                    |
| Parent         | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |

## General Consent for Care and Treatment Consent

***TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).***

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Printed Name of Witness**

\_\_\_\_\_  
**Employee Job Title**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**