CONSENT TO PROCEDURES

CONSENT TO TREATMENT ☐ initial

The undersigned consents for cCARE to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as considered necessary or beneficial by my physician for my health and well-being. The undersigned acknowledges that these services have been adequately explained, and all questions have been answered and that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

PHI ☐ initial

I authorize cCARE to release information from my medical record to my insurance carrier(s), or government agencies for the processing of claims for medical benefits.

FINANCIAL AGREEMENT ☐ initial

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be provided to the patient, he/she is responsible for and obligated to pay the charges. cCARE bills patients' insurance as a courtesy, however, it is the patients' ultimate responsibility for payment for services provided. Co-payments and co-insurance amounts are due at time of service.

ASSIGNMENT OF INSURANCE BENEFITS ☐ initial

I hereby assign payment of the insurance benefits to which I may be entitled, directly to cCARE. cCARE will assist patients in obtaining insurance benefits when those benefits are assigned to cCARE. It is the patient's responsibility to make sure insurance payments are processed and paid promptly.

NOTICE TO MEDICARE PATIENTS ☐ initial

Medicare Authorization (for signature on file): The undersigned authorizes the release of any medical information necessary to process claims. I also request payment of government benefits to the party who accepts assignment.

NOTICE TO MANAGED CARE PATIENTS ☐ initial

Managed care Insurances generally require that a representative, often a Primary Care Physician, authorize services and diagnostic procedures before the plan will accept financial responsibility. Your signature below indicates that you agree to be responsible for payment if you receive services that are not authorized as required by your plan.

RX DISCLOSURE ☐ initial

To better meet our patients' needs we can dispense many of the prescriptions as prescribed by our Providers. We will bill your pharmacy insurance however any co-pay is due upon receipt of the prescription(s). Please understand that you are not obligated to have prescriptions filled by cCARE and you have the option of receiving your medication from the pharmacy of your choice.

PHOTOGRAPH ☐ initial

The undersigned hereby authorizes cCARE to photograph or permit others to photograph them while under cCARE's care. The undersigned agrees the photographs may be used for purposes including, but not limited to, identification, treatment documentation, research, education, and scientific purposes. cCARE will retain ownership rights to these photographs, but that the undersigned will be allowed access to view them. These photographs will be stored in a secure manner that will protect the patient's privacy.

Patient Name (Print): _____ Date of Birth: _____ MRN: _____

Patient's signature: _____Date: _____

If signed by other than Patient

Parent, Conservator/Guardian Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

Signature of Witness: _____

A photocopy of this form may be deemed as valid