

Conditions of Treatment

1. CONSENT TO CARE

I, the undersigned, hereby voluntarily authorize the attending health care provider and/or their assistant, FVH Family Medicine Clinic and its employees to administer any x-ray examination, laboratory studies, medical or minor surgical diagnosis, treatment and service that is deemed advisable.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition.

2. ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize direct payment of medical/surgical benefits to Floyd Valley Hospital Family Medicine Clinic for the services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize FVH Family Medicine Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

3. MEDICARE AND MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

4. RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the health care provider for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not our office. It is your responsibility to pay your deductible, co-insurance, co-payment and any other balances not paid for by your insurance company. We will assist you in receiving reimbursement as much as possible, however, you are responsible for your bill. Should it be necessary to take legal action on this account, you will be responsible for the balance plus interest, all court cost of collection and reasonable attorney fees.

Patient Signature

Date

Parent or Guardian Signature (If patient is a minor)

Print Patient Name _____ Patient's Date of Birth _____

Approved by Risk Management 5/13/10
Consent #2055.doc.consent.administration



Family Medicine Clinics
An Avera Partner