ABC Medical Group
AUTHORIZATION AND CONSENT

CONSENT TO TREATMENT. I voluntarily request Dr. _____ and other providers of ABC Medical Group designated by Dr. _____ (collectively, "Provider") to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice ("Services"). 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 understand that medical care is not an exact science and no guarantees have been made regarding the outcome of treatment.

RELEASE OF INFORMATION. I authorize Provider and any other holder of information about me to disclose all or any part of my medical record or other information needed to determine my eligibility for benefits or the amount of benefits payable for Services rendered by Provider, now or in the future, to any financially responsible party, including but not limited to: the Centers for Medicare and Medicaid (CMS), Medicaid, their intermediaries or carriers, Worker's Compensation carriers, health or liability insurers, or any other insurance organization or billing agent (collectively, "Insurer"). I authorize any holder of medical and billing information about me to release to Provider or any Insurer any information necessary for billing and payment purposes. I consent to the use of a copy of this authorization in lieu of the original.

ASSIGNMENT OF BENEFITS. I request and authorize direct payment to Provider of any Medicare and other insurance benefits payable to me or on my behalf for Services rendered by Provider, now or in the future. I also assign to Provider all of my rights and interest in all such insurance benefits or proceeds, including but not limited to the right to appeal any denial of benefits or to file any lawfully authorized lien necessary to secure payment from any third party or a third party's Insurer. I understand that I am financially responsible for the services rendered by Provider and agree to immediately remit all payments received from insurance for those services. I agree to cooperate with Provider or its agent in collecting any such benefits.

FINANCIAL RESPONSIBILITY. I acknowledge that many Insurers will only pay for services that they determine to be medically necessary and that meet other coverage requirements. For example, some Insurers require prior authorization for certain services. If my Insurer determines that the Services, or any part of them, are not medically necessary or fail to meet other coverage requirements, the Insurer may deny payment for that Service. Notwithstanding any other provision herein, I agree that if my Insurer denies all or any part of Provider's charges for any reason, or if I have no insurance, I will be personally and fully responsible for payment of Provider's charges, as governed by (State) law. Should my account be referred to an attorney or collection agency, I agree to pay actual attorney's fees and collection expenses.

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