# RICHLAND PRIMARY CARE CENTER

Authorization for treatment, release of medical information, and assignment of insurance benefits.

AUTHORIZATION TO RELEASE: I hereby authorize Richland Primary Care Center, my attending physician, or nurse practitioner to release or disclose to insurance companies and/or outpatient benefits programs information from my medical record pertaining to my treatment as needed to process insurance claims.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to Richland Primary Care Center benefits wherein specified and otherwise payable to me but not to exceed Richland Primary Care Center's regular charges for medical treatment. I understand that I am financially responsible for charges not covered by this authorization.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PHYSICIAN/PROVIDER: I certify that the information given by me in applying for payment under the Title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

CONSENT FOR TREATMENT: The undersigned authorizes the physician/provider assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of Richland Primary Care Center. This treatment may require diagnostic procedures including but not limited to laboratory tests, blood drawing for those tests, electrocardiogram, and x-rays.

FINANCIAL AGREEMENT: For services rendered to the patient named below, I, the undersigned, agree to pay all professional and ancillary charges not covered by insurance. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

VALUABLES: The undersigned hereby releases Richland Primary Care Center and/or its staff or employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

IMPORTANT MESSAGE ABOUT WORKER'S COMPENSATION: If we file claims to your personal health insurance and then you later decide to go back and file Worker's Compensation insurance on those expenses, you will be charged a $50.00 service charge, paid in advance. This is necessary due to the complicated nature of billing worker's compensation fee schedules, record keeping issues, insurance adjustments, and the accounting time required for refunding your medical insurance company.

TERM: The term of this Consent for Treatment shall be for a period of one year from the date of signature below, unless otherwise revoked.

| Printed Patient Name | Signature Patient (Guardian if minor) | Date |
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