Consent for Treatment & Patient Financial Responsibility

Consent for Treatment and Acknowledgement of Disclosure and Acceptance of Patient Financial Responsibility

Name of Patient: Date of Birth:
Social Security Number: Driver License Number:

AUTHORIZATION FOR TREATMENT: I authorize the Physician(s) or his/her designee(s), in charge of my or the patient's (named above) care to administer any treatment including medication(s) or vaccine(s) as deemed necessary or advisable in the diagnosis and treatment of any conditions related to me or the patient. This authorization is valid and in effect until such time I withdraw it in writing or in person.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

- I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.
- Co-payments are due at time of service.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service as per FOFHC sliding scale policy.
- I request payment of Government benefits to this provider for the care they rendered; I authorize payment of medical services from my insurance to this provider.

For Medicare Members:

I request the payment of authorized benefits be made either to me or on my behalf to Friends of Family Health Center for any services furnished me by my physician. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named health center any information regarding my Medicare claims under Title XVIII of the Social Security Act. A copy of this signature is as valid as the original.

For Commercial Insurance Members:

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

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Signature of Patient Date

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Signature of Parent/Guardian (if applicable) Date