FINANCIAL RESPONSIBILITY AND AUTHORIZATION
TO DISCLOSE PROTECTED HEALTH INFORMATION

In consideration of the services to be rendered to the patient, the undersigned (as the patient, the patient's legal representative, parent, guardian, spouse, guarantor, or agent individually promises and agrees to pay the patient's account at the rates and terms stated in the Center's price list (known as the "Charge Master") effective on the date of service, which rates are hereby expressly incorporated by reference as the price terms of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or the charge is listed as zero. In the event that the Center has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented to and services provided herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses, including, without limitation, collection agency expenses, incurred by the Center.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Center. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

In consideration of facility, medical, and/or anesthesia services rendered to me or my dependants, I hereby assign and transfer any benefits due me under an insurance policy in so far as they are necessary to cover the expenses. If I maintain an insurance policy, then I, as the policy holder, do hereby authorize the payment of any benefits due me or my dependents under such policy in accordance with this assignment.

You will receive separate bills from the treating and consulting physicians who have provided services to you at the Center.

I authorize the release of medical, protected health and insurance information to the admitting physician, emergency physician, consulting physician, and institutions performing special tests or providing special equipment or supplies. I further request payment of Medicare or other insurance benefits be made to these physicians for professional and technical services rendered (when applicable) while I, or one of my dependents was a patient at the Center. Initial:_____

The Center may use or disclose information about you to bill or receive payment for medical treatment or services and/or supplies provided to you to which you consent to by your signature below. These disclosures include, but are not limited to, releasing information:
1) to your health plan to obtain prior approval or to determine whether your plan will cover the treatment or services; and
2) to individuals or entities involved in collecting amounts owed to us.

I have received this Center's Notice of Privacy Practices. I understand that if I have any questions or complaints I may contact the Center's Privacy Offical. Initial: _____

Signature _____

Patient Date Witness Time

If the patient is unable to sign, complete the following:
□ Patient is unable to sign because _____

_____

_____

Patient Parent Legally Designated Representative

Relationship to Patient if Patient does not sign _____

I give permission for my protected health information to be disclosed for purposes of communicating results, findings, care decisions, billing & financial to the family members and others listed below:

Name_____ Name (Billing & Financial)_____

Name_____

_____

Signature of Patient

WHITE = Chart *YELLOW = Patient or Guardian*

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PATIENT IDENTIFICATION