# 1960 FAMILY PRACTICE & DIGITAL IMAGING

## Conditions of Service

**PATIENT_____ DOB_____ ACCT#_____**

X____ Initials

**Assignment of Benefits**
I, or authorized representative/legal guardian acting on behalf of the patient hereby authorize payment of insurance benefits under the terms of my policy directly to 1960 Family Practice, PA / Digital Imaging (the "facility") for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

X____ Initials

**Financial Agreement and Statement of Responsibility**
For and in consideration of services rendered or to be rendered the facility, I agree to pay said clinic for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered charges. **I understand payment in full is due at the time services are rendered or payment arrangements are to be made before my appointment. I understand that the amount quoted by the facility as being my responsibility is an estimate only and any patient balance remaining after my insurance has processed my claim will be billed to me and due within 30 days.** I understand that it is my responsibility to inform the office with a minimum of a 24 hour advance notification if I am unable to make my appointment. I understand that I will be charged a fee for not giving proper notification.

X____ Initials

**Consent to Medical Treatment by Physician**
I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures, in office surgical procedures and such medical treatment as the physician, his/her physician assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at the facility.

X____ Initials

**Acknowledgement of Review of Privacy Practices**
I, the undersigned, have reviewed the Privacy Practices, which explains how my medical information will be used and disclosed. I understand that the facility may use several resources to communicate with me including email, phone, text, mail and fax and I do authorize the facility to communicate PHI with me using these methods. I understand that I am entitled to receive a copy of the Privacy Practices.

X____ Initials

**Release of Patient Healthcare Information**
I hereby authorize the facility and any medical subcontracted providers, **to release or obtain** patient healthcare information, including but not limited to reports, prior films/images, test results, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the purpose of providing current continuum of care including to facilitate reimbursement by a health benefit plan or third party payor, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency. The healthcare providers of 1960 Family Practice may consult with a specialist for the coordination of you care. These specialists may contact you directly on behalf of your 1960 Family Practice physician.

X____ Initials

**Physician Ownership Disclosure**
This is to inform you that your physician may or may not have an investment interest in the facility, lab, or pharmacy you are referred to. This information is being provided to you to help you make an informed decision about your healthcare. Should you be referred to a facility, lab, or pharmacy at any time and you prefer to use a different provider, you will be advised of alternatives. You should not be treated differently by your physician, physician's staff or the facility if you chose to choose a different facility.

X____ Initials

**Disclosure to Friends and/or Family Members:** I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

| _____ | _____ |
|---|---|
| **Name** | **Relationship** |
| _____ | _____ |
| **Name** | **Relationship** |
| _____ | _____ |
| **Name** | **Relationship** |

**Do you have an advanced directive (living will)? _____ Yes _____No** If yes, please bring a copy into our office for our files. If no, and you would like information on and advanced directive, please speak with your physician.

**X**_____ _____
Patient/Guarantor Signature Date

**The above authorizations are valid unless you revoke them in writing**.