CONSENT FOR TREATMENT - ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name: ____ **DOB:** _______/______/_____

1. CONSENT TO TREAT: I authorize my treating physician and other healthcare providers to order for me all forms of diagnostic testing and treatment which they judge to be appropriate. I request and authorize Beacon Medical Group and Its agents and employees, to provide all treatment services to me as directed by my physicians. I acknowledge that no representation or guarantees have been made to me as a result of the treatment of care.

2. ASSIGNMENT AND RELEASE: I have medical insurance and assign directly to Beacon Medical Group physicians all medical benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. In the event of default of payment, I agree to pay all costs of collections including attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all my insurance submissions.

3. FINANCIAL AGREEMENT: I will make every effort to actively assist Beacon Medical Group with securing payment for services rendered for which I am liable. If I am the parent/guardian of a minor patient, I understand that unless addressed in my third party payer agreements, I am financially responsible for all services rendered, and that the parent who authorizes treatment will be responsible for any balance due. I understand that Beacon Medical Group submits claims to insurance carriers to assist its patients and that I am responsible for the balance owed at any time unless other arrangements have been made. I understand that my third-party payer may require me to obtain prior/post-authorization in order to cover services. I understand that if I do not provide sufficient and timely information and releases of information for Beacon Medical Group to process insurance claims, I will be responsible to pay Beacon Medical Group full and standard fees. I consent to receiving auto-dialed and/or artificial or prerecorded message calls to my cellular and/or line telephones from Beacon Medical Group or its contracted agencies.

4. STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER (PHYSICIAN): I request that payment of authorized Medicare benefits be made on my behalf to Beacon Medical Group for services furnished to me by a Beacon Medical Group clinic, including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and Its agents any information needed to determine these benefits or benefits for related services.

5. STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER (PHYSICIAN): I request that payment of authorized MediGap benefits be made on my behalf for any services furnished to me by a Beacon Medical Group clinic, including physician services. I authorize any holder of medical information about me to release to (My Insurer) any information needed to determine these benefits or the benefits payable for related services.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENTS.

This consent/authorization will remain in effect until revoked by responsible party.

____	____	_____/____/____
Printed Name of Patient/Authorized Representative	Signature of Patient/Authorized Representative	Date

RECEIPT OF HIPAA PRIVACY NOTICE: I acknowledge that I have received or I have been provided the opportunity to receive a copy of the “Notice of Privacy Practice.” I understand the Notice of Privacy may change over time and that the obligations of Beacon Health System, Inc. and my rights under it may change. **Initial:** _______.