Marion Area Physicians, LLC

CONSENT TO MEDICAL CARE AND TREATMENT

While at Marion Area Physicians, LLC office, I consent to all medical care, examinations and tests which have been determined to be necessary for me by MAP. I understand that the practice of medicine is not an exact science and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made as to the result(s) of any treatment, procedure, or examinations to be performed on me while I am a patient at MAP. I understand that if I refuse treatment that is suggested for me or I do not complete a treatment protocol recommended to me, I will not hold MAP or any individual responsible for the consequences of my refusal or incompletion.

RELEASE OF INFORMATION

I understand that MAP may use my protected health information for a range of purposes including: insurance/payment, eligibility verification, billing and collecting moneys due from me, private and public payers or their agents including insurance companies, managed care entities, my employer, state and federal government programs and the Bureau of Workers' compensation; obtaining pre-admission or continued length of stay certification; quality of care assessment and improvement activities; evaluating the performance or qualifications of physicians and health care workers; conducting medical and nursing training and education programs; conducting or arranging for medical review and audit services; ensuring compliance with legal, regulatory, and accreditation requirements; and public health activities. I authorize MAP to receive or release my protected health information, whether by written, verbal, or electronic means including via secured internet web sites or by facsimile to such employees, agents, or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care. I understand that complete, accurate health information must be readily available for my medical care. Therefore, I authorize MAP to release health information to referring physicians, or agency(ies) in order to facilitate continuity of care. I understand the information shared with health care professionals as a result of this authorization will remain confidential. The preceding authorizations for release of medical information include authorization for the release of information regarding drug and/or alcohol abuse, Human Immunodeficiency Virus (HIV), Acquired Immune Deficient Syndrome (AIDS, or HIV/AIDS related conditions.) This consent is subject to written revocation by me; without revocation, it will expire one year from the date of my signature.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered (and have declined) a copy of Marion Area Physicians' Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for disaster relief or to provide information to family or persons involved in my care.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of my insurance benefits to be made directly to MAP for services provided to me. I understand that benefits could be paid directly to me if I do not provide this authorization.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges not paid by my insurance benefits. I understand that charges due are to be paid within 30 days of receipt of a statement and that failure to pay a balance could result in referral to a collection agency and/or termination from the MAP practice. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid, or other insurance or payers. Services not eligible for benefits may include tests and procedures that are not covered by my insurance plan, or those delivered by health care providers who do not participate in my insurance plan. Non-covered services may also include those my physician determines to be medically necessary, but are later determined to be unnecessary by my insurance plan. I understand that I will be responsible for the costs of these services.

PERSONAL VALUABLES

I understand that MAP does not accept responsibility for any lost, stolen, or damaged personal items. I accept responsibility for those items I choose to keep with me while at MAP offices.

By signing below, I acknowledge that I have read this Consent and Authorization and have been given the opportunity to ask questions and receive clarification so that I fully understand and agree to this Consent and Authorization:

Patient: _____ **Signature** _____ Date: _____

Patient DOB: _____

Patient is unable to consent because __ Patient is a minor or __ other (describe) _____

Signature of Patient's Authorized Representative _____Date:_____

Signature of Witness to Authorized Representative _____ Date: _____