Stephenville Medical & Surgical Clinic, P.A.

- Authorizations, Consents and Agreements -
- Patient Receipt of Privacy Notice -

CONSENT TO TREATMENT: I, the undersigned, as the patient (or on behalf of the patient) do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the practitioner on duty. I understand that no guarantee or assurance has been made as to the results which may be obtained.

FINANCIAL AGREEMENT: I hereby guarantee payment for services rendered at the Stephenville Medical & Surgical Clinic, P.A. I understand that it is the Clinic's policy to collect for charges at the time they are performed and that the Clinic accepts no liability or responsibility in settling disputed claims with insurance companies, employers, or legal cases. I understand that the Clinic holds the patient or responsible party, as stated below, liable for payment of all charges and does not accept an Insurance Company as guarantor of my account. I understand that I will be held responsible for any court costs, legal fees or agency fees which may be incurred in the collection of the account. I further consent and authorize Stephenville Medical & Surgical Clinic, P.A. to release or review my medical record as necessary for determination or collection of insurance benefits and/or in the performance of quality review, maintaining measures of confidentiality and security.

ASSIGNMENT OF BENEFITS: I hereby authorize that any benefits or fees payable to me by any insurance companies be paid directly to the Stephenville Medical & Surgical Clinic, P.A. and/or any ancillary providers. I understand that this order does not relieve me of my obligation to pay the account. I understand that I am responsible for health insurance deductibles and coinsurance.

ACCESS TO MEDICAL INFORMATION: I give consent to release, permit access to, or inspection of my medical records by my Health Plan, State and Federal regulatory authorities and/or their authorized representatives.

MEDICARE & MEDICAID BENEFICIARIES ONLY: I certify that the information given in applying for payment under Title XVIII of the Social Security Act and/or Title XIX is correct. I authorize the release of all records required to act on this request so that payment of authorized benefits be made to Stephenville Medical & Surgical Clinic.

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED IN WRITING BY THE PATIENT.

Signature of Patient or Legally Responsible Party	Relationship to Patient	SMSC Employee
Patient Name (Printed)	Date	Employee Name (Printed)

PATIENT RECEIPT OF PRIVACY NOTICE: I acknowledge that I have received the Stephenville Medical & Surgical Clinic, P.A. *Notice of Privacy Practices*.

Signature of Patient or Legally Responsible Party	Relationship to Patient	Date