Caring Hearts Medical Clinic
Patient Consent To Treatment Form

1. Medical Consent:
I request and authorize my physician and other physicians who may attend to me, their associates and assistants, including those employed by the Caring Hearts Medical Clinic (hereinafter referred to as CHMC), and supervised students to provide and perform such medical care, tests, procedures, drugs and other special services and tests ordered by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no representation, warranties, or guarantees as to results or cures have been made to, or relied upon, by me.

2. Release of Information:
I understand and acknowledge there are instances when information concerning my care, including copies of my medical records and/or billing information pertaining to my medical care, must be used by CHMC or disclosed by CHMC to certain individuals or representatives of agencies or organizations in connection with my care, payment for my care, and other activities related to my care. I also acknowledge that these and other permitted uses and disclosures are more fully described in the Caring Hearts Medical Clinic Notice of Privacy Practices.

3. Assignment of Insurance Benefits:
In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by CHMC and all attending physicians, I hereby irrevocably assign and transfer to said CHMC and all attending physicians, all insurance benefits now due and payable to me under any insurance policy or policies thereof that might be applicable.
I hereby transfer payment of benefits for medical and/or surgical services rendered by physicians for whom CHMC is authorized to charge and bill. I understand that my obligations to pay all charges is not affected by the fact that I have insurance benefits and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing CHMC.

4. Guarantee of Account:
In consideration of any and all medical services rendered by CHMC to the above named patient, I agree to pay CHMC the charges for all services ordered by the CHMC physicians, patient and patient's family including any deductibles, coinsurance or amounts not paid by the patient's insurance plan, including Medicare and Medicaid. If the requirements for referral, second opinion, or pre-certification of my care, as outlined by my insurance carrier, have not been followed, I understand that I will be responsible for all charges incurred.

CHMC and the patient or patient's representative hereby enters into the above agreement. The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status, and further certifies that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement.

_____ _____
Patient's Signature/Person Authorized to Consent and Relationship **Date**

_____ _____
Guarantor of Account if Other Than Patient and Relationship to Patient **Date**

5. Medicare Insurance Benefits:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my own behalf. I understand I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered personal charges. I am also responsible for the Part A deductible for each occurrence of illness and any co-insurance amounts which may become due.

_____ _____
Patient's Signature or Person Authorized to Consent and Relationship to Patient **Date**

I hereby certify that I have witnessed the signature(s) of the patient and/or individual signing on behalf of the patient.

_____ _____
Witness **Date**