CONSENT AND TREATMENT AUTHORIZATION

Patient (or the undersigned representative acting on behalf of patient), who is requiring medical care and or treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic testing procedures and such medical treatment and care as the physician(s) consider to be necessary and appropriate. Patient hereby authorizes NavicentHealth Physician Group affiliates by their physicians, nurses, medical students and other health care professionals to furnish and provide such treatment. I also consent to treatment and care by physicians and healthcare providers who are not employees or agents of NHPG but are authorized by NHPG to provide treatment and care to me as a patients of NHPG affiliate which may be deemed necessary or advisable in the judgment of my physician or other provider. This consent to receive medical treatment includes, but is not limited to, examinations (x-ray or otherwise), laboratory procedures, medications, and medical treatments, and other services which the patient may require.

PATIENT FINANCIAL RESPONSIBILITY FORM

In consideration of services rendered, I hereby transfer and assign to NavicentHealth Physician Group affiliates, including its treating and referring providers and other staff members all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. The physician practice/facility may disclose all or any part of the patient's record (including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the physician practice/facility in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The authorized by the patient as patient's general agent to execute the above and accepts its terms.

Basic Policy: Services provided by our physician should be paid in full at the time services are rendered.
Non-covered services: A payment for non-covered charges is expected at the time services are rendered.
Elective (Cosmetic) services: Payment in full is required prior to seeing the service provider.
Missed Appointments: If a patient cannot present for an appointment, he/she should cancel the appointment (2) business days prior to the scheduled appointment time. Untimely notification and no-shows may result in charge that is not covered by insurance carriers.
Patients with insurance: In accordance with insurance carrier contracts, patients will be required to pay their ***co-payment.*** NHPG will submit charges for services rendered to the insurance carrier. If the insurance carrier determines there is a patient balance owed a statement will be sent. All balances should be paid upon receipt of statement.
Returned checks: Payments made by check to NHPG that are not honored by the bank will incur a returned check fee of $30.00.

Medicare/Medicaid Patients: I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. Patient requests that the payments of authorized benefits be made to NHPG. I hereby certify all insurance pertaining to treatment shall be assigned to the Related Medicare/Medicaid claim. Patient assigns the benefits payable for services rendered by NHPG affiliates and treating physicians and authorizes NHPG affiliates and treating physicians to hereby certify all insurance pertaining to treatment shall be assigned to the physician practice treating me.

I understand that certain insurance claims may be filed as a courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges any co-pay, and other pay a percentage of the charges. I understand it is my responsibility to pay deductible, coinsurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed (90) days will be referred to an outside collection agency.

I have read, understand, and agree to the above financial agreement for payment of all fees. The patient/guarantor is ultimately responsible for all fees.

Patient's Signature: _____ **Date:** _____