GILCREASE MEDICAL GROUP

OFFICE RELEASES AND POLICIES

Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician or practice. I also authorize the provider to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.

X Signed: _____ Date: _____

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by GILCREASE MEDICAL GROUP. I authorize any holder of medical or other information about me to release to Medicare and its agents and any information needed to determine these benefits or benefits for related services.

X Signed: _____ Date: _____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand that there may be services provided which are not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service and I may be billed for such related services subsequently. I also understand that I am expected to provide a current copy of my insurance card at the time of service or the appointment may be rescheduled or delayed.

X Signed: _____ Date: _____

CO*NSENT FOR TREATMENT*: I hereby authorize the provider, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable for the condition for which I am being examined.

X Signed: _____ Date: _____

HIPAA CONSENT: I have received a copy of the Health Insurance Portability and Accountability Act. I also understand that it is a HIPAA requirement to provide a pictured ID at the time of service unless one is already on file that could be used for identification. The following is a list of the names of people with whom I agree to have my Protected Health Information released to:

Name: _____ Relationship: _____ ‘

Name: _____ Relationship:_____

X Signed: _____ Date: _____

NO SHOW POLICY: Patients who fail to present for a scheduled appointment without contacting the practice to cancel the appointment within 24 hours prior to the appointment will be considered “no show”. Patients who consistently fail to present for scheduled appointments will be considered “chronic no shows”. A “chronic no show” is defined as having 3 missed appointments in a rolling 12 month period. Patients will be notified of the “no show” policy at the time of registration. Patient appointment status will be updated in our schedule software as a “no show”. On the 3rd missed appointment the patient is billed $25.00 and may possibly be sent a letter discharging them from the practice and shall be blocked from scheduling another appointment. Discharging a patient from the practice is a decision of the provider.

I have read and understand the above stated policy.

X Signed: _____ Date: _____

ADVANCED DIRECTIVES: Based upon government guidelines all patients are to be offered the opportunity to request “Advanced Directives” to be placed in their medical records in the event that and untoward event should occur which renders them incapable of making clinical judgements on their own. In the event that the patient desires to complete an Advanced Directive, the front office staff shall offer a sample “Advanced Directive” form to be completed by the patient and signed.

I have been asked about whether I have or would like to have an “Advanced Directive” placed in my medical records to direct the provider about decisions made on my behalf in the event that I become incapable of making those decisions.

X Signed: _____ Date: _____