Authorization to Treat

I ______________________________, hereby authorize the staff of Americare Health, to provide me with medical treatment. I agree to inform Americare Health, if I have any concerns about my medical treatment at the time services are being rendered.

We/I _________________________, the parents/guardian of _____________________give Americare Health, and its employees the right to treat my son/daughter or legal ward.

Release of Information

The medical records concerning patient care are the property of Americare Health, and are maintained for the benefit of the patient, the medical staff and the center. I hereby authorize Americare Health to release information and or copies of my medical records to physicians, any guarantor of payment on my account, insurance companies for which I have assigned benefits for my treatment of care. This includes authorization to release information pertaining to: psychiatric and or psychological care, alcohol and/or substance abuse, serologic test results (including but not limited to Acquired Immune Deficiency Syndrome or positive HIV results). I authorize the provider to use all available means of communication to transmit such information, including electronic mail or electronic fax transmissions. **Initial:** _______

Medicare

Medicare patients are required to pay for services as they are rendered, and we will submit your claims as a courtesy to you. Medicare also has a $124 deductible that must be met. Medicare recipients are required to present their enrollment cards at the onset of care. Medicare patients are responsible for 20% of the visit unless you have a co-insurance. However we do not accept Medicaid. **Initial:** _______

Workers Compensation

You are responsible for getting authorization through your employer and to obtain workers compensation billing information. **Initial:** _______

Auto Accident or Liability Insurance

If you have been involved in an auto accident, we require a copy of the accident report, a copy of your coverage selection page, auto policy and health insurance information. If an attorney is involved, you must return the doctor's lien form within 10 business days. **You are considered a CASH patient until the above requirements are met! Initial:** ______

General Insurance

We will call the insurance company for verification of benefits as a service. We will send a claim/bill to your insurance company as a courtesy. Please sign the HCFA and Assignment of Benefits Form. This will enable us to submit a bill to your insurance company. **You are responsible for all deductibles, co-pays, and non-covered services at the time services are rendered. Until the above requirements are satisfied and your insurance is verified, you are on a cash pay basis.**

Private-Self Pay

Payment is expected at time of service. We accept **Cash, Checks, and Credit/Debit Cards.** In the unlikely event that your check is returned unpaid, you understand and agree that your check will be collected electronically or redeposit by paper draft. We will electronically collect the maximum returned check processing charge allowable by state law. **Initial:** ______

Radiology

I understand that if my treatment requires radiology procedures (x-ray), it is my responsibility to inform the medical staff if I am pregnant or think I may be pregnant. **Initial:** ______

_______ *NOTICE OF PRIVACY POLICIES PRACTICES* ACKNOWLEDGMENT OF RECEIPT

I have read and understand the above office policies.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (*or had the opportunity to read if I so chose*) and understood the Notice.

Patient Name (please print): Last: ____________________ First: _____________________

- -

I understand that if symptoms persist I should seek additional medical care. **Initial:** ______

Signature: ____ **Date:** ___________________