CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION, AND PRIVACY NOTICE ACKNOWLEDGEMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES:** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician.
2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION:** In consideration of services rendered, I hereby transfer and assign to North Point Physicians, LLC, 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 clinic 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.
3. **FINANCIAL AGREEMENT:** 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 hereby individually obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing and received a copy thereof and is the patient or is duly authorized by the patient's general agent to execute the above and accepts its terms.
4. **MEDICARE/MEDICAID *(if applicable)*:** Patient's certification authorization to release information and payment request. 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 carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me.
5. **I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic.**
6. I understand that certain insurance claims may be filed as **COURTESY.** However, if the claim is denied for any reason, I am responsible for payment. Please remember that 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 charge**. I understand that it is my responsibility to pay any DEDUCTIBLE AMOUNT, CO-INSURANCE, or ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OF THIRD PAYOR WITH A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.**

The undersigned certifies that he/she has read and understands the foregoing and as a patient or the patient's agent, authorized to execute the above, and accepts all its terms and conditions.

X_____ _____ _____

Patient Signature/Authorized Agent: **Date:** **Print Patient Name/Authorized Agent:**

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT:

I have received on this, or a prior occasion, the North Point Physicians, LLC, Notice of Privacy Practice and I acknowledge that I have a copy of the notice or that I requested, and was given a copy.

Received Copy This Date: __**X**__**YES** ____ **NO** Previously Received Copy: ____**YES** ____ N**O**

X_____ _____ _____

Patients Signature: **Date:** **Witness:**

Patient unable to acknowledge receipt of the Notice of Privacy ☐ Patient refused to sign acknowledgement ☐