Patient Consent to Treatment, Assignment of Benefits and Guarantee of Payment

Patient Name: ____________________________ **Date of Birth:** __________________ **Today's Date:** ______________

As a condition of my and/or my child's treatment by First Choice Medical Group, I hereby agree to the following:

Authorization to treat:

I hereby authorize physician(s) at First Choice Medical Group (FCMG) to perform any and all medical examinations and treatments which may now, or during the course or my care as physician(s) deem advisable and medically necessary. I understand that under the direction of my treating physician(s), Physician Assistants and Advanced Registered Nurse Practitioners may be used in my care.

General Office Visits, Testing and Purchases:

I acknowledge that I am responsible for all co-pays, deductibles, and all subsequent financial responsibilities for medical services. All co-pays are due at the time of service. I acknowledge that if I owe a balance for services previously provided, FCMG may refuse to provide additional services until the balance is paid in full.

Surgical:

I acknowledge that in the case of surgical procedures, any insurance authorizations that FCMG obtains apply only to the services performed by FMCG physician(s) and staff, and do not apply to the anesthesiologist, radiology, hospitals and their employees, surgery center and their employees, laboratory services, or any other provider(s) or facilities outside of FCMG. I will contact the individual provider of these services and/or their insurance carrier for information. If the FCMG physician uses an assisting surgical physician's assistant during my surgical procedure, my particular insurance company may or may not pay for these services. I acknowledge that receiving pre-authorization for a surgical procedure does not guarantee that the insurance company will pay for all costs associated with the surgery. I also acknowledge that there may also be specific components of my surgical procedure that my insurer may deny as not covered or pay on a reduced schedule. These denials are specific to the insurance carrier and it is my responsibility to contact my insurer for complete explanation of benefits and payments.

I acknowledge that injections are not covered under the surgical global period, usually 90 days after surgery, and a copayment will be due post-operative visits for x-rays or injections. I understand it is my responsibility as the patient to note what services are covered under my insurance and I am responsible for making sure all visits are authorized by my primary care physician as needed.

Assignment of Insurance Benefits:

I hereby assign, grant and transfer to FCMG, now and in the future, all of my right and interest in the following: (a) any and all benefits now or in the future owed or receivable by me or on my behalf from any insurer, health maintenance organization (HMO), preferred provider organization (PPO), employer health benefit plan or other third party payor for those costs I incur in receiving services from FCMG. The insurance policies and insurer include but are not limited to: health, auto, uninsured motorist (UM), and personal injury protection (PIP); and (b) any and all monies or other benefits paid or payable to me and/or my attorneys from any settlement, judgment or verdict which is obtained as a result of the injury or medical condition for which my debt to FCMG was or is to be incurred. I further authorize, request and direct any and all assigned insurers to pay directly to FCMG the amount due me in any potential or pending claim for benefits under the respective policies, expressly including all PIP policies.

I agree that should the amount received by FCMG be insufficient to cover the entire expense of service, including to the co-payment and the deductible, I will be personally responsible for the payment of the difference. I also understand and agree that if the natures of the services rendered by FCMG are not covered by said insurance policy, I am responsible to FCMG for payment of the entire bill.

Guarantee of Payment:

For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay FCMG all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including co-payment and/or deductible. Treatment includes but is not limited to physician office visits, diagnostic testing, injections, supplies, medications and any and all services rendered by FCMG physicians and staff. Unless specifically agreed to in writing, all charges shall be paid at time of service or upon presentation of the first bill from FCMG, I understand and agree that if FCMG is required to bring a claim or file an action to enforce the agreement, FCMG shall be entitled to recover from me it's reasonable attorney's fees, expert fees, court costs, and any other costs of collection, in addition to the amount owed FCMG for its services.

I have read this agreement and fully understand it.

____ ______________________

Patient Signature **Date**

____ ______________________

Signature & Relationship of Patient's Authorized Representative **Date**

____ ______________________

FCMG Witness Signature **Date**