



# ADVANCED OCCUPATIONAL MEDICINE SPECIALISTS

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Advanced Occupational Medicine Specialists to furnish medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

### **BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to Advanced Occupational Medicine Specialists. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

### **FINANCIAL POLICY STATEMENT**

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share to be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Advanced Occupational Medicine Specialists.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize Advanced Occupational Medicine Specialists, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call 888 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that Advanced Occupational Medicine Specialists cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: Advanced Occupational Medicine Specialists will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to our personal health information the terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution. The undersigned acknowledges receipt of this information.

### **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Center Representative/Witness \_\_\_\_\_ Date \_\_\_\_\_

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