PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("Provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient named below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to cancelling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Name:______________________________ Relationship:________________________ Phone Number:______________
Name:______________________________ Relationship:________________________ Phone Number:______________
Name:______________________________ Relationship:________________________ Phone Number:______________

Initial all applicable information:

_______Medical/Treatment/PHI including retrieval of medical records and prescription refills
_______Lab/Ancillary Testing/Radiology/MRI/Imaging Results
_______Billing/Insurance Information
_______Authorized to leave message on voice mail or by other designated communication systems
_______Other, Describe____

ADVANCE DIRECTIVES FOR HEALTH CARE *(Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare)*

(If applicable to the practice setting, patient to initial appropriate statement):

_______The patient does NOT have an Advance Directive

_______The patient has the following Advance Directive(s): ____
____
and will provide a copy to the attending SMG physician practice

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Print Patient's Full Name *Patient Date of Birth*

_______________________________________ _______________________________________

Print Name of Guarantor/Legal Representative *Relationship to Patient*

_______________________________________ _______________________________________

Signature & Date Signed *Witness to Signature if applicable*