



PATIENT NAME: _____ DATE OF BIRTH: _____

PARENT OR LEGAL GUARDIAN: _____ PRACTICE NAME: _____

AUTHORIZATION FOR TREATMENT

Initial

_____ I authorize the Physician(s) or his/her designee(s) or consultant (s), in charge of the patient’s care to administer any treatment as deemed necessary or advisable in the diagnosis and treatment of any conditions related to the patient. I understand that this authorization is valid and in effect until such time as I withdraw it in writing or in person.

ASSIGNMENT OF BENEFITS, PAYMENT TERMS & RELEASE OF INFORMATION

Initial

_____ As Guarantor of this account, I agree to assign to Concord Hospital Physician Group all insurance benefits otherwise payable to or on behalf of the patient for services rendered. I agree to be held financially responsible for services rendered by the Concord Hospital Physician Group on behalf of this patient that are not covered by insurance. I understand that it is my responsibility to notify Concord Hospital Physician Group of any changes in insurance coverage. I know that I will pay the balance owed if the insurance or personal information I have given is not accurate.

I authorize the release of pertinent medical records to the patient’s named insurance carrier for the purpose of claims coverage. I understand that this applies to all types of insurance coverage, including but not limited to Medical, Worker’s Compensation and Liability/Auto. I understand that the only records released would be pertinent to that date of service and to the carrier providing coverage for that date of service. Failure to provide this authorization may result in the Insurance carrier’s denial of a claim. I have been offered a copy of the practice’s Financial Policy and understand it’s content.

MEDICAL INFORMATION

Initial

_____ In an ongoing effort to provide quality care in a timely and accurate manner, Concord Hospital Physician Group utilizes an electronic medical record (EMR) to capture medical information. This system allows pertinent medical information to be shared among your healthcare providers, including your primary care providers, providers that share call with your primary care providers after hours, consulting providers, emergency department physicians at Concord Hospital as well as other departments within Concord Hospital.
We are committed to protecting your privacy in accordance with applicable state and federal laws.

I acknowledge that Concord Hospital Physician Group maintains medical information in various formats that include, but are not limited to: paper, computer data, digital and other images. This information is made available to my health care providers as appropriate to provide necessary medical treatment.

I have read and fully understand the information above. I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions described above. If I am not the patient, I certify that I am authorized by law to agree to these conditions on the patient’s behalf.

Signature: _____ Date: _____
(Patient/ Legal Guardian/ Guarantor)