THE CONRAD | PEARSON CLINIC

Consent Form

Patient Name: _____ DOB: _____ **Chart #:** _____

I consent to medical treatment by the physicians of Conrad Pearson Clinic (CPC) for myself or my minor child if named above.

I request that payment of authorized Medicare/Medicaid and/or other health insurance benefits be made on my behalf to the physicians members of CPC for any services furnished me by that provider. I consent to the release of my medical information or the medical information of my minor child if named above to the Health Care Financing Administration or my designated insurance company or health plan for the purposes of determining benefits payable for the services provided to me or my minor child if named above by CPC or its physician members.

I assume financial responsibility and agree to pay upon demand to CPC all charges for services and incidentals incurred by me or my minor child if named above unless otherwise specified under a contract between CPC and my insurance company or health plan. If I am covered under Medicare Part B program, I agree to pay my annual deductible and coinsurance. **Should my account be turned over for collection**, I shall pay an additional 33.3% collection fee or additional 35% collection fee if the account is referred to their legal department (which is the current fee charged by the outside collection agency we use).

I consent to the release my medical, demographic and financial information or the medical demographic and financial information of my minor child if named above for the purpose of filing for insurance or health plan benefits and other financial coverage. CPC is authorized to obtain my medical history from my pharmacy, health plan and other healthcare providers.

I also understand that if I or my minor child if named above, am enrolled in a managed care health plan, I am responsible at each time of service, for informing CPC of any special requirements of my health plan, including but not limited to, how often services may be rendered or where those services may be performed. If I do not inform CPC and services are performed which are not covered, such as lab work, procedures, tests, or hospitalization, CPC or the selected medical facility will bill me directly for those charges. Payment for those charges is then my responsibility.

CPC requires a twenty-four (24) hour cancellation notice for a scheduled medical appointment. Patient no-show or cancellation without a twenty-four (24)-hour notice will incur a $50.00 charge for each missed appointment unless precluded by law or contract. This charge is the responsibility of the patient and cannot be billed to or reimbursed by your insurance company or health plan. This fee must be paid in full prior to your next scheduled appointment.

_____ I consent to CPC texting me at _____ for appointment reminders and information regarding my health

_____ I have read, understand and approve all the information provided to me above regarding payment for services rendered to me or my minor child if named above.

_____ I consent to CPC calling me at _____ and leaving a message at this number for appointment reminders, to provide test results, for consultation and other reasons associated with my treatment or payment for my treatment. I understand that these contacts have the potential to break confidentiality

_____ I consent to CPC emailing me at _____for appointment reminders, to provide test results, for consultation and other reasons associated with my treatment or payment for my treatment. I understand that these contacts have the potential to break confidentiality.

_____ I have received a copy of the CPC Notice of Privacy Practices.

_____ _____

Patient's Signature (or Custodial Parent/Legal Guardian if Patient is Minor) *Date*

For Office Use Only: CPC was unable to obtain acknowledgement due to: □ Emergency □ Patient sedated □ Patient non-responsive □ Patient refused- Reason: