THE CONRAD | PEARSON CLINIC

Authorization Form

Patient Name: _____ DOB: **_____Chart #: _____**

I understand that my home, answering machine, voice mail messaging, and/or office will be called in the normal course of business:

to remind me of appointments
to leave messages that the physician or nurse need to talk to me or to leave test results
to initiate other necessary contacts

These contacts have the potential to break confidentiality. ***I agree to these contacts.***

_____ _____
Signature of Patient/Guardian *Date of Signature*

***Note:* If you do not agree to the above terms, you may make arrangements to have all contacts regarding medical issues conducted in person at our office.**

I, _____, have received a copy of The Conrad | Pearson Clinic's (CPC) Notice of Privacy Practices.

_____ _____
Signature of Patient *Date*

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

I authorize the physicians of CPC to treat me, or my minor child who is named above, medically.

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 authorize any holder of medical information about me to release to the Health Care Financing Administration or my designated insurance company any information needed to determine these benefits or the benefits payable for related services.

I agree that for and in consideration of acceptance by CPC for services rendered to me, hereby obligates me, and I assume financial responsibility and agree to pay upon demand to CPC all charges for such services and incidentals incurred by me, unless otherwise specified under my contracted PPO/HMO agreement. 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 understand that all bills are payable upon presentation and that I, not the insurance company, am responsible for the payment of all services.

I hereby authorize CPC to release all sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

I also understand that if I am enrolled in a managed care insurance plan, I am responsible at each time of service, for informing CPC of any special requirements of my insurance plan, including but not limited to, how often services my 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 $50.00charge for each missed appointment. This charge is the responsibility of the patient and cannot be billed to or reimbursed by your insurance company. This fee must be paid in full prior to your next scheduled appointment.

I have read, understand and approve all the information provided to me above.

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