Authorizations and Assignment of Benefits

I authorize and consent to physicians, allied health professionals, and employees of the Crossing Rivers Health Clinic to carry out the following:

Treatment: To furnish medical care and services, including but not limited to diagnostic tests, examinations, and other medical procedures which are in the judgment of the physician/provider, necessary to the diagnosis and treatment of my illness or condition. I recognize that medicine is not an exact science and that my diagnosis and treatment involves risks. Further, I acknowledge that no guarantees have been made to me as the result of examinations or treatments while in this clinic.

Release Information: To release medical information to third party payors who may request detailed documentation in support of bills submitted for the services provided to me as a patient. To release medical information to other health care organizations or providers who may provide continuing care. Also, the use of information in my record for proper medical, scientific, educational or research purposes; for automated or other processing of designated information; for official surveys for clinic compliance with accreditation, regulatory and licensing standards; and for the purpose of complying with all other applicable statutory or regulatory provisions.

I understand that I may review and copy my medical records at my own expense and this review shall take place in the clinic during regular business hours.

Assignment of Benefits: Insurance assignment in the event the undersigned is entitled to benefits of any type whatsoever including major medical arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Crossing Rivers Health Clinic for application on patient’s bill, and it is agreed that the clinic may receipt for any such payment and such payment shall discharge the said insurance company of, and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by this assignment.

Medicare Certification: I certify that the information given by me for payment under Title XVIII and Title XIX of the Social Security Act is correct, I request that payment of authorized benefits be made on my behalf directly to the Clinic and to the involved physicians/providers.

Notice of Privacy Practices Acknowledgement Form: I acknowledge that Crossing Rivers Health Clinic has provided me with a copy of the Crossing Rivers Health Clinic Notice of Privacy Practices document. I understand this form means only that I have received the Notice and in no way affects the care I receive at Crossing Rivers Health Clinic.

Statement of Financial Responsibility:
I certify that the information given by me is true and complete to the best of my knowledge. I understand that I am financially responsible for all charges incurred in this visit, including any amount not paid by my insurance plan(s), interest, collection fees or attorney costs in the event the account becomes delinquent.

Date: ____________________ Time: __________________ Witness: ___________________________

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Patient Parent, Legal Guardian, Authorized Representative

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State Relationship to Patient