CONSENT TO TREATMENT

I am presenting myself for examination and treatment at LGH Medical Group, LLC and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the practice, and by its medical staff, or their designees, as in their professional judgment be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the practice.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

Date	Print Name	Signature of Patient or Responsible Person**	Relationship

** By signing above, I acknowledge that LGH Medical Group, LLC has informed me of their **Notice of Privacy Practices** for the protection and security of my healthcare information. I also acknowledge that upon request, LGH Medical Group, LLC will provide me with a copy of their **Notice of Privacy Practices**.

FINANCIAL CONSENTS

Release of Information: Assignment of Benefits, Payment Guarantee

AUTHORIZATON TO RELEASE INFORMATION: LGH Medical Group LLC is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any information pertaining to the diagnosis and/or procedures relative to this practice visit(s). A photo copy of this authorization shall be considered as effective and valid as the original.

ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY: In consideration of services rendered, I hereby forever assign and give to LGH Medical Group, LLC all rights, title and interest in the benefits payable for services rendered by said practice, provided by my policy (ies) of insurance. This transaction shall be for the recovery on said policy (ies), but shall not be construed to be an obligation of LGH Medical Group, LLC to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company (ies) to pay directly to LGH Medical Group, LLC all benefits due under said policy (ies) by reason of services rendered therein. I shall pay LGH Medical Group, LLC for all charges in excess of the sums actually paid pursuant to said policy (ies). A photo copy of this authorization shall be considered as effective and valid as the original.

Date	Signature of Patient or Parent if Minor

MEDICARE CERTIFICATION
(Medicare Patients Only)

Patient's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize LGH Medical Group, LLC to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to LGH Medical Group, LLC or one of its affiliates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I assign payment for the unpaid charges for certain physician's services. I understand that I am responsible for any health insurance deductibles and coinsurance.

Date	Signature of Patient

AUTHORIZATION TO RELEASE INFORMATION

I allow LGH Medical Group, LLC to speak to _____ (Name) _____ (Relationship) regarding my care.

I allow LGH Medical Group, LLC to leave a message at my home or cell regarding any appointments and/or normal test results.

Date	Signature of Patient or Parent if Minor

CONSENT TO HEALTH INFORMATION EXCHANGE

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

Date	Signature of Patient or Parent if Minor

LGH Medical Group, LLC
Office Policy

FINANCIAL

Our office will make every attempt to bill your health insurance carrier for medical services rendered to you. It is your responsibility to provide us with timely and accurate information regarding your insurance policy. Please keep us updated as changes occur.

Your insurance policy is a contract between you and your insurance company. As providers, our relationship is with you, the patient. You are responsible for knowing your coverage. Our providers make every attempt to recommend medical care that is essential to your health. Please know your policy's limits and contact your insurer to verify coverage if you are not sure.

_____
Initial

CO-PAYS / DEDUCTIBLES

All co-pays and/or deductibles are due at time of service. Patients with co-insurances and self-pay accounts are expected to make a payment at the time of service. Co-pay/deductibles apply to all visits in our practice, including non-provider clinical staff.

*** Please be advised you may not have a fee for preventative care. However, if both preventive and diagnostic care occur at the same visit, you may have a fee associated with the diagnostic service. Your provider will determine the proper coding after your visit and we will bill you if necessary.*

_____
Initial

CANCELLATIONS / NO-SHOWS

We request at least a 24-hour notice if you need to cancel your appointment. A missed or cancelled appointment with less than a 24-hour notice may be subject to a $50 fee for new patients, office procedures and physical appointments, and a $25 fee for follow-up and sick visit appointments.

_____
Initial

LATE APPOINTMENTS

If you arrive more than 15 minutes late for your appointment, you will be seen on a case-by-case basis, depending on the provider's schedule.

REFERRALS

If your insurance requires a referral for your office visits, please be sure to contact your PCP to process the referral. Patients without a referral in place will need to reschedule their appointment until a referral has been processed.

_____
Initial

REFILL REQUESTS

Please contact our office to request prescription refills and allow 72 hours for our office to process.

MEDICAL RECORD REQUESTS

A medical record request form must be completed and submitted via mail, fax or in person. Please allow 10-14 business days for processing. A fee will apply and will vary depending on the number of pages released.

1. I have read and agree to the LGH Medical Group, LLC policy above.
2. This agreement remains in effect for all future services at LGH Medical Group, LLC.

Patient/Responsible Person Signature: _____ Date: _____