Consent For Care:

I hereby give my consent to examination or treatment by the clinic's medical staff, including diagnostic services, medications, laboratory procedures or other medically necessary services.

Authorization To Pay Insurance / Third Party Benefits To Physician or Clinic and Release Information to File Insurance:

I authorize direct payment to the Clinic and other medical providers the health insurance benefits that I am entitled to or are otherwise due or payable to me. I also authorize this office to release any information necessary to assist in getting the insurance claims filed appropriately.

Also, where appropriate, I request that payment of authorized Medicare, TennCare or Medicaid benefits for services provided to me, be made directly to the Clinic or other medical providers. I also authorize any holder of medical information about me to release that information to the Center for Medicare/Medicaid Services and its agents if needed to determine the benefits payable for related services.

Financial Agreement:

I understand that I am responsible for payment of the charges incurred for services provided to me. If I have given health insurance information, the clinic or medical provider will file the claim for the medical services provided. If I do not have health insurance or there is a balance after insurance, I may be responsible for the amount of the bill.

Rx Consent

I hereby authorize the release of medical information required to share and/or receive prescription information for my treatment medication including access of my prescription history.

Acknowledgement of Receipt of Privacy Notice:

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, and may request another copy if needed, by asking the front desk.

The undersigned patient or representative agrees that Methodist Le Bonheur Healthcare, its affiliates and agents, may use an automated telephone dialing system, pre-recorded messages and/or texting, to contact the cellular telephone number(s) that have been provided for appointment, payment and collection purposes. It is my responsibility to provide the clinic with the most up to date information.

By signing below, I understand I may revoke the authorizations in this document at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Signature _____ _____ _____ _____

Patient, Parent or Guardian **Relationship to Patient** **Date** **Time**

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical record. This can include any family member or other healthcare provider.

Name _____ **Relationship to Patient** _____ **Phone Number** _____

Name _____ **Relationship to Patient** _____ **Phone Number** _____