# Financial Responsibility

Patient Name: _____ Date: _____

## INSURANCE AUTHORIZATION

I authorize APA to bill my insurance company for charges incurred during the course of my treatment and to provide any medical information necessary to process my claims. I authorize payment to be made directly to APA and a copy of this authorization may be used instead of the original. I authorize APA to inquire about my accounts and to receive any information about my Medicare or other insurance claims, assigned or unassigned. I understand that I am fully responsible for charges incurred with this treatment even though the doctor files my insurance for me. I understand delinquent accounts are subject to collection and acknowledge responsibility, which also may acquire attorney fees.

_____
Patient Initials

## CONSENT FOR TREATMENT

Permission is hereby given for any medical/surgical, x-rays, drug or laboratory tests, medications or exam as deemed necessary by the Physician, Physician Assistant or Nurse Practitioner. I understand that I may have the right to see a Physician if I chose and have the right to see the Physician prior to any prescription drug or devise order being carried out by a Physician Assistant. In case of an unemancipated minor, the consent below is given by his/her parent/guardian.

_____
Patient Initials

## CONSENT TO OBTAIN/RELEASE MEDICAL RECORDS

I hereby authorize APA to obtain medical records from any other Physician or medical facility necessary in the course of my treatment. Additionally, I authorize APA to release any information acquired in the course of my treatment to other Physicians and medical facilities as needed. I authorize that this acquisition/release may occur by regular mail, fax or e-mail, as necessary. I also authorize the release of any information to a government agency (DEA, GBI, etc.) if requested by said agency.

_____
Patient Initials

## CONSENT TO RELEASE MEDICAL INFORMATION/RECORDS/ACCOUNT INFORMATION TO A SPOUSE or FAMILY MEMBER/FRIEND

I hereby authorize APA to release any information contained in medical record to the person or person indicated below:

YES _____, release to: _____ (please indicate relationship)

NO _____, release to only me.

By initialing the above items, I am stating that I have read the information contained therein. My signature below shows my acceptance of all items defined above.

_____ _____
Signature of patient or responsible party Date