

Patient Consent Form

Name: _____ Date of Birth: _____

Financial Responsibility & Assignment of Benefits

I understand that insurance billing is provided as a courtesy and that I am financially responsible to Benson Medical Group, PS for all charges arising from my treatment. It is my responsibility to notify BMG of any changes in my health care coverage. While BMG verifies my insurance eligibility, exact insurance benefits cannot be determined until the health plan receives the claim. I agree to accept financial responsibility for all medical services or supplies receive by me.

I authorize direct payment from my health insurance plan to BMG for all services and supplies provided to me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. If any law, such as workers' compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer.

Cancellation Policy

We understand that circumstances may arise requiring you to cancel your scheduled appointment. Please try to give us a 24 hour cancellation notice.

Consent for Treatment and Release of Information

I am aware of my diagnosis and wish to receive treatment from BMG. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing, and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to BMG to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize BMG to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

I certify that I have read this agreement and my signature indicates my understanding and consent.

Signature _____ Date _____