

Breast Care Specialists AMC

Christopher S. Sockrider, M.D.

1. CARE CONSENT

I/we consent to service, treatment and diagnostic procedures as may be deemed necessary or advisable by my Dr. Sockrider and/or consultants selected by my physician. The consent to facility care includes permission for X-Ray examinations, laboratory procedures, I.V. treatments, injections, medications and services rendered the patient under the general and special instruction of the doctors. The patient acknowledges responsibility in any or all of these procedures. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, Breast Care Specialists does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to care.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

The employees and agent of Breast Care Specialists AMC and copy services and electronic claims processing services under contract with any third party billing agents or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient care, to another health care provider if the patient was transferred to that facility and to any and all insurance companies or other third parties paying or obligated to pay, in whole or in part, the charges incurred by the patient; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third party payors for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. VALUABLES

I understand and acknowledge that Breast Care Specialists AMC assumes no responsibility for personal possessions including cash, jewelry, bridge work, eyeglasses or any other personal possession. I have been advised that such valuables should not be left unattended and should be placed in the care of my family or custodian.

4. SAFETY CODE

Safety codes are issued and followed by the National Fire Protection Association. Guidelines are strict and safety inspections and drills are performed quarterly.

5. FINANCIAL AGREEMENT (ASSIGNMENT OF BENEFITS)

In consideration for services rendered or to be rendered to the above patient by this medical treatment facility for illness, injury or diagnostic services on the date(s) indicated. I hereby assign to said medical facility all benefits due me covering medical expenses under the identified policy number, insofar as they are necessary to cover such expenses. For further agree that, should the amount paid by the insurance company(s) be insufficient to cover the entire medical expense, I will be responsible for payment paid by the insurance company(s) be insufficient to cover the entire medical expense, I will be responsible for the payment of any prescribed deposit on the date demanded and the remaining balance of the entire bill within (30) days of the date of discharge. I authorize the release of billing information about this patient to any insurance company or other source when this information is required for payment by Breast Care Specialists AMC, or any of its staff physicians involved with patient care.

6. ASSIGNMENT TO PHYSICIANS

I hereby assign to all physicians who treat me the benefits due me for these services covering medical and/or surgical expenses. I agree that should the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physician(s) for the payment of the differences, and that is the nature of the disability such that it is not covered by the policy, I will be responsible to the physician(s) for payment of the entire bill; and that if the nature of the disability, illness or services rendered by such that is not covered, for any reason, by the said policy(s), the undersigned and/or responsible party will be responsible for the payment.

7. MEDICARE CONSENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Breast Care Specialists AMC to provide (SSA) or its intermediaries with access to my medical record for the purpose processing the Medicare claim for this or a related Medicare claim. I further request that Breast Care Specialists AMC provide such copies thereof as may be requested. Copies may be made by Breast Care Specialists AMC or its agents, or contractors providing copy service and electronic claims processing services and said third party billing agents for Breast Care Specialists AMC and staff physicians involved with patient care. This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for the reason(s) indicated below

Patient Signature X _____ Witness _____
Signature of person responsible for bill _____
Relationship _____ Date _____
Patient unable to consent because _____