Reid Health
Physician Associates

# GENERAL CONSENT AND ACKNOWLEDGEMENT FORM

**Patient Name:**_____ **Date of Birth:**_____

## GENERAL CONSENT FOR TREATMENT

I, the patient, or his or her representative, recognize the need for medical and hospital care authorize Reid Health Physician Associates, Inc., its health care employees, allied health personnel and physicians to render such routine non-invasive medical/surgical care, tests, procedures, drugs and other services and supplies under the general and specific instruction of the physician. This form is to provide authorization for "routine" services only and not for complex diagnostic or therapeutic procedures. Except for emergency or extraordinary circumstances, it is my understanding that additional consents will be obtained by the treating physician if more invasive services are to be performed.

I understand and am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee has been made to me as to the result of treatment or examination.

I understand that it is my right to consent, or to refuse consent, to any proposed procedure or therapeutic course.

_____ _____
Patient / Responsible Party Signature Date

## RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I, the patient, or his or her representative, authorize my physician to release information from my medical record to my insurance carrier(s), and/or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

_____ _____
Patient / Responsible Party Signature Date

**Optional sections – Please complete only if highlighted**

## MEDICARE/MEDIGAP AUTHORIZATION (if applicable)

I request that payment of authorized Medigap and/or Medicare benefits be made either to me or on my behalf to Reid Health Physician Associates for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (name of Medigap insurer) and/or the Center for Medicare and Medicaid Services any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient / Medicare Beneficiary Signature Date

## FINANCIAL AGREEMENT

I, the patient, or the patient's representative, acknowledge that I have read, understood and received a copy of the Reid Health Physician Associates Financial Policy. I understand and agree, regardless of my insurance status, that I am responsible for the balance of my account.

In addition, I designate your office, employees, and agents as my representative to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

_____ _____
Patient / Responsible Party Signature Date