PATIENT REGISTRATION CONSENT & ACKNOWLEDGEMENTS

CONSENT TO TREAT

I consent to Signature medical Group (SMG) physicians, practitioners, and other providers ("Provider"), their assistants and staff to provide medical and /or surgical treatment, testing, supplies, medications, services, equipment, and other items deemed necessary for the patient named below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives, and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending provider of any decision to terminate treatment. I agree to provide at least 24 hours' notice prior to cancelling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment, and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies, and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Name: ________________________________ **Relationship:**_____________________ **Phone Number:**____________________

○ **Medical** ○ **Billing** ○ **All**

Name: ________________________________ **Relationship:** _____________________ **Phone Number:**____________________

○ **Medical** ○ **Billing** ○ **All**

Name: ________________________________ **Relationship:** _____________________ **Phone Number:**___________________

○ **Medical** ○ **Billing** ○ **All**

ADVANCE DIRECTIVES FOR HEALTHCARE:

○ I do not have an Advance Directive.

○ I have an Advance Directive and will provide a copy.

Print Patient's Full Name ***Patient's Date of Birth***

Print Name of Guarantor/Legal Representative ***Relationship to Patient***

Signature & Date Signed ***Witness to Signature if applicable***