PIEDMONT MEDICAL
ASSOCIATES

ASSIGNMENT OF BENEFITS, CONSENT TO TREAT, NOTICE OF PRIVACY, AND FINANCIAL AGREEMENT

NOTICE OF DEEMED CONSENT: WHEN EITHER A PERSON PROVIDING HEALTH CARE SERVICE OR A PATIENT IS DIRECTLY EXPOSED TO THE BODY FLUIDS OF THE OTHER IN A WAY THAT MAY TRANSMIT HUMAN IMMUNO-DEFICIENCY VIRUS(HIV) OR HEPATITIS VIRUSES, SUCH OTHER PERSON IS DEEMED TO HAVE CONSENTED TO TESTING FOR THOSE VIRUSES AND TO RELEASE THE TEST RESULTS TO THE PERSON SO EXPOSED, AND ACTUAL CONSENT IS NOT REQUIRED. (INT___)

CONSENT TO TREAT, ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE ANY MEMBER OF PIEDMONT MEDICAL ASSOCIATES (PMA) AND/OR THEIR DESIGNATES TO PROVIDE MEDICAL TREATMENT, RELEASE OF INFORMATION PERTAINING TO TREATMENT FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR INSURANCE PURPOSES, AND TO RECEIVE DIRECT INSURANCE PAYMENTS FOR PROFESSIONAL TREATMENT OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN ESTABLISHED. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR VALID INSURANCE INFORMATION, REQUIRED BY THEIR MANAGED CARE CARRIER, OR THEY WILL BE FINANCIALLY RESPONSIBLE FOR THE ENTIRE BALANCE DUE. THE UNDERSIGNED AGREES TO BE RESPONSIBLE FOR COURT COSTS, ATTORNEY'S FEES ASSOCIATED WITH COLLECTION PROCEDURES BROUGHT BY PMA AND A $35 RETURN-CHECK CHARGE, SHOULD THAT BECOME NECESSARY. (INT___)

DISCLOSURE OF INFORMATION: WE MAY DISCLOSE YOUR MEDICAL INFORMATION TO OPERATE THE PMA PRACTICE PLAN. FOR EXAMPLE, WE MAY USE YOUR MEDICAL INFORMATION IN ORDER TO EVALUATE THE QUALITY OF HEALTH CARE SERVICES, TO EVALUATE THE PERFORMANCE OF THE HEALTH CARE PROFESSIONALS, AND TEACHING AND TRAINING OF HEALTH CARE PERSONNEL. WE MAY ALSO PROVIDE YOUR MEDICAL INFORMATION TO OUR ACCOUNTANTS, ATTORNEYS, CONSULTANTS, AND OTHERS TO MAKE SURE WE'RE COMPLYING WITH THE LAWS THAT AFFECT US. (INT___)

NOTICE OF PRIVACY PRACTICES: I HAVE BEEN OFFERED THE PMA PRIVACY NOTICE WHICH DESCRIBES HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED BY PMA AND ITS AFFILIATES. (INT___)

PATIENT RESPONSIBILITY: I UNDERSTAND THAT FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR MYSELF AND ANY PARTY FOR WHOM I AM FINANCIALLY RESPONSIBLE. I UNDERSTAND THAT IS SOLEY MY RESPONSIBILITY TO CONFIRM WHICH TREATMENTS OR PROCEDURES ARE COVERD AND/OR PAID BY MY INSURANCE (INCLUDING, BUT NOT LIMITED TO, ANY APPLICABLE EXCLUSIONS, DEDUCTIBLES, AND ANNUAL OR LIFETIME MAXIMUMS). ANY CLAIMS DENIED AS A RESULT OF ME PROVIDING INCORRECT INFORMATION (NAME, DOB, SUBSCRIBER INFORMATION, CORRECT INSURANCE CARRIER AND ID INFORMATION, etc.) MAY RESULT IN MY RESPONSIBILITY

TO PAY FOR THE CLAIM. I UNDERSTAND THAT ALTHOUGH I PAY MY ESTIMATED PATIENT BALANCE ON THE DATE OF SERVICE, THE INSURANCE ESTIMATE MAY DIFFER FROM WHAT MY INSURANCE CARRIER ULTIMATELY PAYS. I WILL BE RESPONSIBLE FOR ANY AMOUNTS NOT PAID BY MY INSURANCE FOR ANY REASON, AND I MAY RECEIVE A BILL/STATEMENT FOR A BALANCE DUE.

(INT___)

CANCELLATION POLICY: WE ATTEMPT TO SCHEDULE AS EFFICIENTLY AS POSSIBLE TO REDUCE WAIT TIMES. WE REQUIRE PATIENTS TO CANCEL APPOINTMENTS 24 HOURS PRIOR TO THE SCHEDULED DATE AND TIME. A FEE WILL BE ASSESED TO ALL APPOINTMENTS CANCELLED WITH LESS THAN 24 HOUR NOTICE. THE FEE IS $50.00 FOR OFFICE VISITS AND $100.00 FOR PHYSICALS. WE UNDERSTAND THAT EMERGENCIES MAY OCCUR THAT PREVENT THE REQUIRED NOTIFICATION, EMERGENCIES WILL BE ADDRESS ON A CASE BY CASE BASIS. ALL RETURNED CHECKS WILL BE ASSESED A 35.00 FEE, THIS FEE MAY INCREASE DEPENDING UPON THE BANK'S CHARGES. (INT___)

MEDICAL RECORDS REQUEST AND FORMS: I UNDERSTAND THAT UNLESS RECORDS ARE SENT DIRECTLY TO ANOTHER PROVIDER, THE CHARGE FOR COPIES UP TO THE FIRST 50 PAGES IS $35.00 AND .25 CENT PER PAGE FOR EACH ADDITIONAL PAGE AFTER 50. ALL FORM REQUEST TO BE COMPLETED INCLUDING (DMV, FMLA, APPLICATIONS FOR EMPLOYMENT, DISABILITY FORMS, ASSISTED LIVING, NURSING HOME, SHOR AND LONG TERM DISABILITY, ECT.) WILL ASSESED A $45.00 FEE. (INT___)

PATIENT NAME (PRINT) PATIENT OR RESPONSIBLE PARTY'S SIGNATURE DATE

PMA STAFF DATE