CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES & TREATMENT

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of First Physicians Group and his/her designee(s).

FINANCIAL AGREEMENT

The undersigned individually obligates him/her and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that First Physicians Group has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to SMH Physician Services, Inc. for services rendered to me. I authorize payment directly to First Physicians Group of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance, or any governmental programs such as Medicare, Medicaid, or Worker's Compensation and authorizes First Physicians Group to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in First Physicians Group including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents any information needed to determine these benefits or benefits for related services.

_____
Name of Beneficiary

_____
HIC Number

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to First Physicians Group for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to any information needed to determine these benefits payable for related services.

_____
Name of Medigap Insurer

_____
Name of Beneficiary

_____
Medigap Policy Number

NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the revised SMHCS Notice of Privacy Practices that describes how First Physicians Group may use and disclose my health information, and also describes my rights regarding my health information.

INSURANCE PRECERTIFICATION

I understand that, **before service is rendered**, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance. I understand that First Physicians Group may assist me with obtaining authorization and/or referral for services from time to time by either contacting my insurance company directly or hiring an outside company.

EVALUATION OF SERVICES AND FOLLOW-UP

I give permission for First Physicians Group and/or its agent(s) to contact me for the purpose of evaluating the services rendered to me. ❑ Yes ❑ No

The undersigned certifies that he/she has read and **understands all of** the above, fully accepts all specified terms therein, and **has received the information on patient rights, including the mechanism for initiation, review, and resolution of complaints and has been offered a copy of the revised 6/01/2017 SMHCS Notice of Privacy Practice. ☐I have declined a personal copy of the revised SMHCS Notice of Privacy.** I further understand that the SMHXchange is a Health Information Exchange (HIE) that grants providers involved in my healthcare access to my most recent visits. I can change my authorization for SMHXchange at any time by calling (941) 917-6622.

Signature of Patient or Legally Authorized Representative	*Print* Name of Patient or Legally Authorized Representative	/ / Date
Signature of Guarantor of Payment (state relationship if other than patient)	*Print* Name of Guarantor of Payment	/ / Date
Signature of Witness	*Print* Name of Witness	/ / Date