Lewis County Primary Care Center Doing Business As...

PrimaryPlus

Quality ✚ Advanced ✚ Affordable ✚ Healthcare

Name of Patient:_____ Date of Birth:_____

Physicians of: *Lewis County Primary Care Center, Inc./ DBA PrimaryPlus*

Date:_____ Time:_____ (a.m.) (p.m.)

1. I, _____(parent/guardian) acting on behalf of _____(patient) am suffering from a condition requiring medical, podiatric and/or dental care. I agree to receive this care. It may include routine diagnostic and medical treatment that the attending physician(s) or others of the health center medical staff consider necessary.
2. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me about the result of examination or treatment in this health center
3. I understand that:
   (a) Normally, except under emergency or extraordinary circumstances, no important procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professionals to the patient's satisfaction;
   (b) Each patient has the right to agree or refuse to agree to any proposed procedure or therapeutic course; and
   (c) No patient will be involved in any research or experimental procedure without his or her full knowledge and agreement.
4. I realize that there are medical, nursing and other health care personnel at this health center who are still in training. I understand that they may be present during my care unless I request them not to be present.
5. This form has been fully explained to me, and I am satisfied that I understand its content and significance.

Date of Agreement:_____

_____ _____

*(Patient's signature)* *(Signature of witness)*

* If the patient is unable to consent or is a minor, complete the following:

Patient (is a minor _____ years old) OR (is unable to consent because

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I HEREBY CONSENT FOR THE FOLLOWING PERSON/PERSONS TO BRING MY UNDERAGED CHILD TO LEWIS COUNTY PRIMARY CARE CENTER, INC FOR TREATMENT.

_____ _____

_____ _____

_____ _____

_____ _____

Parent or Legal Guardian Date

_____ _____

Witness Date

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ASSIGNMENT & RELEASE: I, the undersigned certify that I (or my dependent) have insurance coverage with _____And assign directly to Dr._____

All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Dr. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship Date

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ _____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to the insurer or agency shown. In Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date