NORTH MISSISSIPPI MEDICAL CLINICS

CONSENT FOR TREATMENT, ADMISSION,
AND RELEASE OF HEALTH INFORMATION

NAME OF PATIENT: _____

DATE: _____

PATIENT NUMBER: _____

1. **CONSENT FOR TREATMENT:** I request and voluntarily consent to the usual medical services while a patient at **NORTH MISSISSIPPI MEDICAL CLINICS, INC.** ("Clinic"), as well as the diagnostic laboratory (testing of the blood and other bodily fluids) and x-ray procedures (including intravenous injection of contrast material) and medical treatment, including administration of anesthesia and other treatment as deemed necessary by my physician, his assistants or other designated physicians. The Clinic is authorized to retain, preserve, and use for scientific or teaching purposes, or dispose of, at its convenience, any specimens or tissue removed from my body during treatment. I understand that photographs may be taken for clinical and/or educational purposes and hereby consent thereto. I also understand that if any such photographs are taken for educational purposes, any and all such photographs will not be retained as a part of my permanent medical record.

2. **MEDICAL CARE:** During treatment at Clinic, I, as a patient, will be under the professional care of a physician. I understand that no guarantees have been made as a result of examination or treatment while in the Clinic.

3. **COMPLIANCE WITH RULES AND REGULATIONS:** In consideration of admission and/or treatment, I agree to abide by the rules of the Clinic, including no smoking except in designated areas.

4. **PERSONAL VALUABLES:** Valuables, including money, jewelry, glasses, dentures, documents and other personal Items should be kept at home. I agree that the Clinic will not be liable for the loss or damage to any personal property that I may bring to the Clinic.

5. **RELEASE AND RESPONSIBILITY:** I hereby agree, acknowledge and understand that the Clinic is not responsible for injuries sustained by use of my own personal equipment - electrical, mechanical or otherwise. I further understand and agree that should I leave the Clinic without the consent of my physician(s) (against medical advice), I hereby relieve my physician(s) and the Clinic of all responsibility tor such action.

6. **CONSENT TO DESTROY X-RAY AND GRAPHIC DATA:** I hereby authorize the Clinic to dispose of, at its discretion, any specimens or tissues taken from my body and to retire x-ray film and any other graphic data which may be generated, four (4) years after they are created if a proper report is in the medical record. However, to the extent any such x-rays and/or other graphic data are stored in a digital and/or electronic format, Clinic may dispose of such x-rays and/or other graphic data, at its discretion, six (6) years after they are created.

7. **ASSIGNMENT OF BENEFITS:** As a patient, I hereby make the assignment of benefits as set forth below:

   MEDICARE AND/OR MEDICAID: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by the Clinic, shall be made to the Clinic, and I specifically assign such benefits to the Clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. **I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Program and that I may be responsible for the entire charge incurred unless other third party coverage is available.** I also understand all deductibles are due unless they have been met within the period specified by Medicare.

   INSURANCE: I hereby assign to Clinic all rights, benefits and interest under any insurance policy, health plan, workers' compensation or other third party payor liable to me, in consideration for services rendered by the Clinic. I hereby authorize payment directly to Clinic by any insurance policy, health plan or third-party payor for treatment received at the Clinic. I hereby authorize payment directly to the Clinic of Worker's Compensation coverage for medical expenses for medical treatment received at the Clinic. I hereby authorize payment directly to the Clinic of all third-party liability insurance coverage, third party payor, health plan and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury or illness for which I received treatment at the clinic.

8. **FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible to the Clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges and other items not paid by insurance, health plan or other third party payors are due and payable upon admission based on the best estimates available as determined by Clinic. Charges remaining on this account not covered by insurance, health plan or other third party payor, are payable upon demand. I also agree that in case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expenses will be paid by me. I also understand, agree and authorize Clinic to verify employment status for the purpose of processing my Clinic bill for payment.

9. **NON-CERTIFICATION OF ADMISSION:** I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third-party payor, I am responsible for assuring certification is obtained from the insurance company, third-party administrator or health plan for the treatment provided. If certification is not obtained, I further agree that in the event the insurance, health plan or other third party payor denies either all or part of the payment on the Clinic account, I will pay the account in full upon demand from the Clinic.

10. **CONSENT FOR THE RELEASE OF HEALTH INFORMATION FOR BILLING AND PAYMENT PURPOSES:** I hereby consent to the release of my health information (medical records, medical results and any and all other health information) by Clinic or any physician involved in my care for the purpose of: billing; claims management; medical data processing; eligibility documentation; reimbursement; and certification to any insurance company, third party payor, health plan or government agency which is necessary for the billing and payment of my account.

11. **CHARITY CARE**: I understand that if I am uninsured and unable to pay for care, that financial assistance may be available. If I need assistance, I can contact the clinic's office manager for further information about financial assistance for uninsured patients. I understand that charity assistance will be denied if I fail to truthfully, and timely, provide information to verify my eligibility.

12. **NOTICE OF PRIVACY PRACTICES:** (Check appropriate box)

Acknowledgment: I acknowledge that I have been given and received a copy of the North Mississippi Medical Center' hospital and North Mississippi Medical Clinics' Notice of Privacy Practices. Your acknowledgment does not mean you agree with our Notice of Privacy Practices or that you have read our Notice of privacy practices; it only means you acknowledge receipt of a copy.

Acknowledgment if patient is a minor or otherwise incompetent to sign: I hereby acknowledge that I have been given and received a copy of the North Mississippi Medical Centers' hospitals and North Mississippi Medical Clinics' Notice of Privacy Practices on behalf of patient. Your acknowledgment does not mean you agree with our Notice of Privacy Practices or that you have read our Notice of Privacy Practices; it only means you acknowledge receipt of a copy.

13. **CONSENT TO CONTACT:** I hereby authorize the Clinic and its respective employees, agents and contractors to contact me about obtaining potential financial assistance for my account(s) and/or for collection services about my account at the current or any future telephone number (including wireless telephone numbers) listed with my account. I hereby agree that methods of contact may include using pre-recorded or artificial voice and/or an automated telephone dialing system.

14. **TELEHEALTH SERVICES:** I understand that telehealth services provided will be done through a two-way audio/video link with a healthcare provider. I understand that a physician will examine me with the assistance of trained personnel. I understand that this examination will be done through a two-wayaudio/video link and that I can ask the exam and/or video conference be stopped at any time. I understand there are potential risks including, but limited to, interuption and/or disconnection of the audio/video link, a picture not clear enough for the needs of the consultation, and electronic tampering.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ PARAGRAPHS 1-14 OF THIS DOCUMENT, UNDERSTAND ITS CONTENT, AND AGREE TO ITS TERMS.

_____ _____

Signature of Patient Date Time

_____

Clinic Witness to Signature

WHEN PATIENT IS A MINOR OR INCOMPETENT TO GIVE CONSENT: I hereby consent for the Patient.

_____ _____

[Signature of Authorized Person] Date Time

_____

Relationship to Patient

_____

Clinic Witness to Signature