

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT, AUTHORIZATION TO RELEASE INFORMATION, AND PRIVACY NOTICE ACKNOWLEDGMENT

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other series rendered the patient under the general and special instructions of the patient's physician. _____ (Initials)

2. ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION In consideration of services rendered, I hereby transfer and assign to Titanium Healthcare all rights, title and interest in any payment due to me for services describe herein as provided in the above-mentioned policy or policies of insurance. The clinic may disclose all or any part of the patient's record (including psychiatric, alcohol and alcohol and drug abuse, family member or employer of the patient for all or part of the clinic's charge, including but not limited to medical service companies, insurance companies, workman's compensation carriers, welfare funds or the patient's employer. _____(Initials)

3. FINANCIAL AGREEMENT The undersigned agrees, weather he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rated and terms of the clinic. Should the account be referred to an attorney for collection expense, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patients as patient's general agent to execute the above accepts its terms. _____(Initials)

4. MEDICARE/ MEDICAID Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _____(Initials)

5. USE OF COPIES I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at the clinic. _____(Initials)

6. PAYMENT RESPONSIBILITIES I understand that curtained insurance claims may be filed as courtesy. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. I understand it is my responsibilities to pay any CO-PAY, DEDUCTIBLE, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITHIN A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS. _____ (Initials)

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I have received on this, or a prior occasion, the Titanium Healthcare, Notice of Privacy Practice and acknowledge that I have a copy of the notice or that I requested, and was given a copy.

Received copy this date: Yes No Previously received copy: Yes No

Patient /Legal Representative: _____ Witness: _____

Patient unable to acknowledge receipt of the Notice of Privacy: _____

Patient refuses to Sign Acknowledgment: Reason: _____

PATIENT'S NAME

PATIENT'S SIGNATURE

DATE

SUBSCRIBER SIGNATURE (if different than patient)

DATE
