OceanMed Clinic
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Consent to Treat, Assignment of Benefits & Privacy Form

Thank you for choosing OceanMed Clinic. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

1. Consent for Treatment

I consent to evaluation and treatment by under the direction of the physicians of OceanMed Clinic, including his/her associates and assistants. I understand this could include examinations, lab tests, EKGs, education, or other diagnostic tests. I understand that my provider is available to explain the treatment and I have the right to refuse service.

2. Professional Service Insurance Release & Assignment of Benefits

I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me or my dependents by OceanMed Clinic I also authorize payment of benefits directly to OceanMed Clinic, for services provided to my dependents or me. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered. (A photocopy of this authorization shall be considered valid).

3. Insurance

We participate in many insurance plans, specifically PPO plans. If you are not insured by a plan, we do business with or do not have an up-to-date insurance card, payment in full is expected at each visit. For Medicare, when you provide us with current and complete information, we bill primary and secondary insurances. Please contact your insurances company with any questions you may have regarding your coverage. We are not accepting HMO insurance. You will be charge at time of your service.

4. Referral

I understand that if my insurance requires a referral from my Primary Care Provider for specialist services and if I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, it will be my responsibility to contact my Primary Care Provider's office the same day and obtain the necessary referral, dated for the date of service. I also accept full financial responsibility for all charges incurred for services received on the day of service if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

5. Payment

I accept financial responsibility for payments for all services and products received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check, or credit card. There will be $15 processing fee if copay and/or deductible must be billed and is not paid at the time of service. I also understand there will be an additional $25 processing fee for collection accounts and bounced checks for each date of service.

6. Non-Covered Services

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance. i.e., Food allergy tests and Immigration Medical Exams.

7. Cancellation Policy

I understand that OceanMed Clinic has a 24-hour Cancellation Policy for appointments and a charge of $150 if I do not call to cancel or reschedule my appointment a day before my appointment. Immigration Medical Exam Cancellation: A $150 fee penalty will be charged if the appointment is cancelled.

8. Patient Authorization

I authorize OceanMed Clinic to send copies of my records to other physicians as needed for continuity of care. I understand this is a group practice and other doctors may be involved in my care. I agree and understand that a copy of my medical records including AIDS, HIV behavioral health service, psychiatric care and treatment for alcohol or drug us will be included as part of my health information. I also agree that OceanMed Clinic Associates can release my medical records to accrediting or regulatory agencies if those agencies request my records and if the law allows these agencies to see my records.

9. Authorization to Communicate Private Health Information

I authorize OceanMed Clinic to leave messages on my answering machine, voicemail, email and or text messages to my form of communication provided on the PATIENT REGISTRATION FORM.

OceanMed Clinic will share private health information with family or others when we feel it's in the patient's best interest to share appointment or other care information. This means we will answer family questions and confirm appointment information if the inquiry is made on behalf of the patient. If you do not agree with our policy, please provide the names of individuals who may answer your phone, with whom we should *not* share information:

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1. Patient's Right to Privacy

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have on HIPAA Notice of Privacy Practices on display in the reception area. This document describes in detail how information about you, the patient, can be used within our office and with others who need to know reason for treatment, payment, and/or health care operations. If we were to disclose your information for any other reason, we would first need your written approval. A printed copy of the HIPAA notice will be provided upon request.

By signing below, I attest I have read the above and authorize OceanMed Clinic to treat, bill and share my medical information as discussed above.

Signature of **Patient** / **Parent or Guardian** (if minor)

X_____ Today's date: _____

Patient or Guardian Name (if minor) _____ **Date**_____

Relationship to Patient_____ **(for minor)**