

TrueMedicine, P.A.
Authorizations and Consents 2012

Financial Agreement and Assignment of Benefits

I agree to pay for services rendered. If applicable, I agree to pay for any co-payments at the time of service, and I understand that I will be fully responsible for any services deemed as non-covered or denied by my insurance company. I also understand that there may be a patient responsibility balance even after my insurance company has made a payment. Page | 1

I agree to comply with any request by my insurance company or TrueMedicine, P.A. to assist in quick and efficient payment of my medical claim.

I accept that it is my responsibility to understand and verify that the physicians of TrueMedicine, P.A. are in-network with my insurance plan including any facilities that I may be referred to for surgery, physical therapy, further testing, and/or other types of ancillary services.

If my insurance company requires a referral to see a specialist, I agree to be ultimately responsible for obtaining my referral, along with the assistance of a representative from the specialist's office.

Payment can be made in the form of cash, verifiable check, and/or credit card. There will be a \$25.00 per check charge for all returned checks as having non-sufficient funds.

I certify that I am at least 18 years of age and/ or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below. Further, I assign insurance benefits for all services rendered to TrueMedicine, P.A. Additionally, I agree to release all such medical information as may be necessary to assist in payment of medical claims.

Receipt Acknowledgement for the Notice of Privacy Practices

I have been made aware of the Notice of Privacy Practices for TrueMedicine,PA. I understand that this notices states how TrueMedicine,PA may use and disclose my Protected Health Information ("PHI"). I understand that a copy of this notice is available upon request.

Consent for Treatment

I authorize TrueMedicine, PA to perform all exams, tests, procedures, injections, and any other care deemed necessary and advisable for the diagnosis and treatment of my medical condition(s).

Consent for Release and Acquisition of Medical Records

I authorize the use and disclosure of the name of treating physician(s), the nature of my treatment and my projected outcome, collectively referred to as "Limited PHI"-Protected Health Information. I understand that demographic information as well as dates of service may also be disclosed.

I authorize my treating physician(s) to make the authorized use and/or disclosure to institutionally related offices.

I understand that once my Limited PHI is used/ or disclosed pursuant to this authorization, it may no longer be protected by the HIPPA privacy regulations and may be subject to re-disclosure by the recipients.

I understand I have a right to revoke this Authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that I have authorized the use of my PHI and such use and/or disclosure has been relied upon by authorized recipients.

2800 State Hwy 114, Suite 130 Trophy Club, Texas 76262
• 817.490.9841 • 817.490.9838 fax

Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize Truemedicine,PA to release my records and images to the following individuals. (This should include friends or family members responsible for picking up your records when you are unable to do so. Appropriate Identification must be shown to receive records. PLEASE PRINT.

1. Name _____ Date of Birth _____
2. Name _____ Date of Birth _____

Patient Notification Preferences

I hereby give permission to TrueMedicine,PA to disclose and discuss any information related to my medical conditions to/with the following persons, such as relatives or close personal friends.

1. Name _____ Relationship _____
2. Name _____ Relationship _____

_____ **I do NOT wish to give permission for additional family members, relatives or friends to have access to any information regarding my medical conditions.**

I wish to be contacted in the following manner

Home Telephone:

OK to leave message with detailed information Yes ___ No ___
OK to leave message with call back number only Yes ___ No ___

Work Telephone:

OK to leave message with detailed information Yes ___ No ___
Ok to leave message with call back number only Yes ___ No ___

Cellular Phone:

OK to leave you a detailed message on your voice mail Yes ___ No ___
Ok to leave message with call back number only Yes ___ No ___

Receipt Acknowledgement of TrueMedicine,PA Office Policies

I have been made aware and accept TrueMedicine,PA. Office Policies. I understand that a copy of this policy is available upon request.

Authorized Signature

Printed Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date of Birth: _____ Date Signed: _____

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