CONSENT TO TREATMENT, RELEASE AND ACKNOWLEDGEMENT FORM

Patient Name: ____

CONSENT TO TREATMENT

I request those physicians and other healthcare professionals who care for me to perform routine examinations, diagnostic procedures, hospital care and therapeutic treatments, which in their judgment, become necessary while I am a patient of the Physician Practice. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests and administration of medications. I also consent to medical recording or filming necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care, performance improvement and education. I acknowledge that I have the right to request stopping of any recording or filming during the filming and up until a reasonable time before the recording or film is used.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize the Physician Practice to retain, preserve and use for scientific, or educational purposes, or dispose of at their convenience, any specimens or tissue taken from my body. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

I, understand that the Physician Practice, in order to deliver quality healthcare, develops and maintains health information which may include physician notes, history and physical, medication reports, tests and test results, and treatment plans. I concur that this health information is used for the following:

- care and treatment plans
- billing statements
- communication between interdisciplinary healthcare providers
- verification of services by third party payers and government payers
- quality control by the Physician Practice

CONSENT TO APPEAL

In the event that my insurance company denies payment for any services rendered during this episode of care, I authorize the Physician Practice to file a grievance for payment on my behalf; I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to the Physician Practice filing a grievance on my behalf, I understand that I will not be able to file my own grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent shall automatically be rescinded and I may file my own grievance if my health care provider does not file a grievance, or stops grieving my case.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Physician Practice for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND PHYSICIAN

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to D.P.W. for payment.

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered, however, in the event that I am entitled to medical care benefits of any type whatsoever, I hereby assign those benefits to the Physician Practice and any of its contracted health care providers. I authorize the Physician Practice and the appropriate health care providers to apply for benefits on my behalf for services rendered during this admission or visit. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with applicable Physician Practice, provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to contact my personnel office and/or insurance carrier to obtain it. If I fail to do so, I could be liable for all or part of otherwise covered expenses.

ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF MEDICAL BILL

I guarantee payment of all charges incurred for services rendered by Allegheny Specialty Practice Network for the patient named on the opposite side of this page, less any amounts paid by any third party payor. I guarantee the amount due for non-insurable charges including co-payment, deductibles, etc. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Physician Practice's Notice of Privacy Practices ("Notice"). I understand that information the Physician Practice acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND ITS CONTENTS.

______________________________	______________________________
Signature	Witness
_______Patient _______Substitute Decision Maker	____________________**DATE COMPLETED**
______________________________	______________________________
If Substitute Decision Maker, state relationship	If Substitute Decision Maker, state reason