MAB
MEDICAL ASSOCIATES OF BREVARD
A Multi-Specialty Group Practice

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Board Certified in Internal Medicine
Cardiovascular Disease
Interventional Cardiology

CONSENT TO TREAT AND PROVIDER-PATIENT AGREEMENT

1. **CONSENT TO TREAT:** I authorize any treatment(s) agreed to by me with the physician which may be deemed advisable. This may include but are not limited to laboratory procedures, diagnostic exams, medical or surgical treatment, procedures, anesthesia, emergency treatment, or other services rendered to the patient by the physicians and/or medical staff on behalf of the physicians.

2. **ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION, COMMUNITY CHART CONSENT**: I authorize payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard, LLC for services rendered. I authorize the disclosure of my medical records to Medical Associates of Brevard as well as to my insurance companies for the purposes of payment and treatment. I give consent to Medical Associates of Brevard LLC to access the Community Chart in order to access and share my medical records if available through other entities operating under the CareQuality Interoperability Framework, including Surescripts.

3. **FINANCIAL POLICY:** I understand that I am financially responsible for all charges for services provided to me including copays, coinsurance, deductibles and noncovered services. I understand that payment may be requested before or at the time of service. I understand that I will be billed for any patient balance after my insurance has processed claims and that the final payment of this account is my responsibility. I agree to pay balances within a reasonable period of time not to exceed 60 days unless special arrangements are made with the provider. I further agree to pay collections and reasonable attorney's fees should I default on payment.

4. **MEDICAL BILLING POLICY:** I understand that my doctor's office will make reasonable efforts to bill and obtain payment from my insurance for services provided to me but that the office does not guarantee payment from or service coverage by my insurance. If a claim is denied or not paid by my insurance for any reason, I am responsible for payment except where federal or state law prohibit. I understand it is my responsibility to provide current and accurate insurance policy information to the office and must do so prior to my appointments. I understand that insurance is considered a method of reimbursing the physician and practice for medical services I am voluntarily receiving. I understand that I have the right to request a price estimate prior to services by contacting the provider's office and my insurance company.

5. **NO SHOW POLICY/LATE POLICY:** I understand No-show fees may be applied to missed appointments if the office is not provided 48-hour cancellation notice and that repeated no-shows may result in termination from the practice. I understand that the office may be unable to accommodate my appointment if I am late if it affects another patient's appointment. Emergencies, or reasons outside patient's control will be considered and exempt from the no-show policy.

6. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have reviewed, received, or have been offered a copy of the PROVIDER NOTICE OF PRIVACY which describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment for services, or in the performance of office healthcare operations.

7. **CONSENT TO OBTAIN EXTERNAL PRESCRIPTION (Rx) HISTORY**: I authorize Medical Associates of Brevard LLC and its physicians and staff to view my external Rx history via electronic medical records system Medent, and Surescripts services. I understand that Rx History from multiple other unaffiliated medical providers, insurance companies, and pharmacy managers may be viewable by my providers and staff here and may include prescriptions back in time several years.

8. **ACO**: I have received, reviewed, or have been offered a copy of the Medicare Shared Programs Accountable Care Organizations Beneficiary Notice.

LIFETIME SIGNATURE AUTORIZATION: THIS SIGNATURE AND ASSIGNMENT IS TO BE A CONTINUING ONE, REMAINING IN EFFECT UNTIL REVOKED IN WRITING BY THE UNDERSIGNED. IT SIGNIFIES THAT THE PATIENT, LEGAL REPRESENTATIVE OR SURROGATE UNDERSTANDS AND AGREES TO THE PRACTICE POLICIES AS OUTLINED ABOVE.

PATIENT SIGNATURE:_____ **DATE:**_____

PRINT NAME:_____ **DOB:**_____

LEGAL REPRESENTATIVE SIGNATURE:_____ **DATE:**_____

LEGAL REPRESENTATIVE PRINTED NAME:_____