VALLEY MEDICAL PRIMARY CARE, INC.

6611 Clyo Road, Suite E, Centerville, OH 45459
Phone: 937.208.8282 Fax: 937.208.8275

AUTHORIZATION FOR TREATMENT AND FINANCIAL DISCLOSURE

Authorization for Treatment

Authorize examinations, diagnosis, and general treatment (including but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of VMPC. If necessary, I also give my permission for all the allied health professionals (social services, nutritionists, physician assistant, nurse practitioners, etc.) to review my medical record for the purpose of evaluating my overall health needs. I realize that if a medical procedure or surgery is required, I will be given additional information.

Release of Information

Thereby authorize VMPC to furnish information from patients' medical records to any health care provider my physician deems necessary to provide for the continuity of my medical care. Please list any inclusions (information regarding substance abuse, mental health, sexually transmitted diseases, etc. in the following space:

Thereby authorize VMPC to furnish information from the medical record to my insurer, compensation carrier or health care facility which may be providing financial assistance for my care.

Thereby authorize holder of any medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable for related services. Thereby authorize Medicare to furnish VMPC any information regarding my Medicare claims under the title XVII of Social Security Act.

Financial Agreement

I realize my bill is my responsibility. I assign and authorize payments be made directly to VMPC of all insurance benefits and agree to pay any balance due.

I have read the above; I understand and accept these terms. If I refuse treatment or leave the facility, I hereby release the physician and VMPC of all responsibility of my action. I am aware of the above contents, but understand that, except to the extent that action has been taken based on my authorization, I may withdraw my authorization at any time by written notification to the parties involved.

If you have any questions, please discuss them with us at the time of service.

There will be a $25.00 charge, which is not payable by insurance, for any no shows with less than a 24-hour notice. This will also be applicable to Medicare patients effective January 1st 2014.

Beginning, January 1, 2014 there will be a $40 charge, for every check that is returned to us for insufficient funds. We will NOT accept any post dated checks, as the office policy is to do daily deposits.

I assume financial responsibility for care given whether or not an insurance company is involved.

Signature: _____ Date: _____

Print Name: _____