PATIENT RESPONSIBILITY FORM/FLINT HILLS FAMILY MEDICINE

Patient Name: _____
Please print

◆ PAYMENT OF SERVICES

I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier.

_____ _____
PATIENT SIGNATURE (OR PARENT FOR MINOR) **DATE**

◆ INSURANCE BENEFITS AND INFORMATION RELEASE FORM

I hereby authorize the Doctor to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the Doctor for any services rendered that are not paid for directly by me.

_____ _____
PATIENT SIGNATURE **DATE**

◆ MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to physician/provider for any services furnished me by that physician/provider.

I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
PATIENT SIGNATURE **DATE**

◆ AUTHORIZATION TO TREAT MINOR

As the parent/guardian of the above named child/minor, I hereby give permission to the Doctor above to treat the child/minor in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to the Doctor for charges for medical services rendered.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

◆ AUTHORIZATION TO TREAT PATIENT

I hereby give permission to the doctors of Flint Hills Family Medicine to treat the listed. My consent for any procedures in the office is implied. I will ask prior to any procedures for clarification of anything I do not understand regarding the procedures and or treatment plan. I understand that many problems that come into a primary care office are in a undifferentiated state and may take some time to sort themselves out. I also give consent for any lab tests drawn and/or xrays taken. I will notify the xray technologist is there is any chance I may be pregnant.

_____ _____
PATIENT SIGNATURE **DATE**