BUXMONT PULMONARY & SLEEP MEDICINE, PC

CONSENT FOR SERVICES

PLEASE READ CAREFULLY AND SIGN THE NECESSARY AUTHORIZATION AND AGREEMENTS SO THAT WE MAY PROCEED WITH THE CARE AND TREATMENT ORDERED.

1. CONSENT TO SERVICES: I hereby consent to the rendering of care, which may include diagnostic procedures and such medical treatment, as the named attending physicians(s) or others of the Buxmont Pulmonary & Sleep Medicine, staff considers to be necessary. I understand that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me as the result of examination or treatment in this office.
2. RELEASE OF INFORMATION: To obtain payment or services, I hereby authorize the physician(s) providing services to disclose my insurance carrier copies of my medical record. I recognize that the information disclosed may contain information that is protected by federal and state law, and I specifically consent to disclosure of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.
3. ASSIGNMENT OF BENEFITS: I hereby assign Buxmont Pulmonary & Sleep Medicine physician(s) providing medical services while I am a patient at Buxmont Pulmonary & Sleep Medicine for my treatment.
4. FINANCIAL AGREEMENT: The undersigned, is consideration of the services to be rendered to the patient, acknowledges the obligation to pay Buxmont Pulmonary & Sleep Medicine in accordance with its regular rates and terms and if the account is referred to an attorney or agency for collection, to pay reasonable attorneys' fees and collection expenses. The undersigned agrees to be responsible for charges not covered by insurance. It is understood that the obligation to pay may not be deferred for any reason, including pending legal actions against other parties to cover medical costs.
5. FOR MEDICARE PATIENTS: I have read the above and fully understand its content. I certify that the information given by me applying for payment under the title XVIII of the Social Security Act is correct.
6. I acknowledge the receipt of the Patient Privacy Practices Notice.

The undersigned certifies that he/she has read the above and is the patient, guardian, or representative authorized to execute the above and accept its terms.

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Signature of Patient Signature of Authorized Person Relationship to Patient

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Signature of Witness Date