Summit
MEDICAL SPECIALISTS

3821 Vincent Station Dr.
Owensboro, KY 42303

PATIENT AUTHORIZATION RECORD

1. **CONSENT TO TREATMENT.** I voluntarily consent to care involving routine diagnostic tests, procedures and medical treatment as ordered by my physician. I agree that, as part of the medical procedures or tests that may be performed on me, I may be tested for HIV infection, hepatitis or other blood-borne infectious diseases if a physician orders the test for diagnostic purposes or in the event of exposure to health care personnel. No one has guaranteed the results that may be obtained from my care.

2. **OTHER PRACTIONERS AND HEALTH CARE EDUCATION.** I understand and acknowledge that if my physician orders additional services such as radiology studies or laboratory tests, these may be performed or the results interpreted by health care personnel who are NOT employees of Summit Medical Specialists but who are independent contractors or employees of an independent contractor. I agree that Summit Medical Specialists is not responsible for and does not assume any liability for the activities of any physician or practioner who is not its employee. As independent contractors, these physicians and other health care providers may bill me separately for their services. I also understand that, from time to time, students in health care occupations, including but not limited to nursing, physical therapy, radiation therapy, and laboratory sciences, may observe and participate in my care in a supervised environment and I agree that, by signing this document, I am consenting to such student observation and participation.

3. **PHOTOGRAPHS.** By signing below, I consent to photographing (including still and video photography) of myself or parts of my body as deemed necessary for inclusion in my medical record for patient identification/safety and treatment.

4. **NOTICE OF PRIVACY PRACTICES.** Summit Medical Specialists Notice of Privacy Practices which states how it may use and disclose medical information. **I acknowledge that I have received the Summit Medical Specialists Notice of Privacy Practices.**

5. **ASSIGNMENT OF BENEFITS.** By signing below, I agree to direct payment to Summit Medical Specialists of any third-party benefits otherwise payable to or on my behalf for the care Summit Medical Specialists provides to me, including emergency services if rendered. Payment to Summit Medical Specialists by a third-party payor shall discharge the payor of obligations under my policy to the extent of such payment, I agree to pay for all charges that are not covered by any third-party payor to the extent allowed by law. If my bill must be turned over to a collection agency, I agree to pay Summit Medical Specialists attorney's fees and collection expenses. I agree that this statement applies to all current and future claims.

6. **BILLING.** In order to permit Summit Medical Specialists to bill for the services it has provided to me, I agree to furnish or arrange to have furnished to Summit Medical Specialists any and all information needed to process my insurance claim and, if I have no insurance coverage, a signed agreement to make payment arrangements. I authorize Summit Medical Specialists to receive from the Social Security Administration any Medicare eligibility information necessary to process my account.

7. **INSURANCE AND EMPLOYERS.** I hereby authorize Summit Medical Specialists to disclose information about my care to my insurance company for obtaining payment for the services I receive. I acknowledge and agree that if my medical condition appears to be a work-related injury, Summit Medical Specialists may provide information about my care to my employer or its worker compensation insurance carrier, if applicable, as necessary to collect payment for services rendered.

8. **FOR MEDICARE RECIPIENTS ONLY.** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers or to the Professional Review Organization any information needed for this or a related Medicare claim.

9. In order for us to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including cell phone numbers, which could result in charges to you. If the patient provides Client or its agents with his/her cell phone number, the patient authorizes Client or its agents to call his /her cell phone manually or by auto-dialer in order to collect any amounts the patient owes.

10. **No Show Policy.** We strive to provide the best care to our clients. We schedule your visits according to care plans that optimize your wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our clients who are dedicated to improving their wellbeing.

    If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 24 hours in advance. If you must cancel your appointment, fail to show up for your appointment, or are late for your appointment more than two times you will be discharged from our practice.

    I, _____ (print name), agree that a copy of this patient authorization record may be used in place of the original copy. I acknowledge that I have read and understood all the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient, I certify that I am authorized by law to agree to these conditions of admission on the patient's behalf.

_____ _____ _____

Date **Patient/Parent/Guardian/Power of Attorney** **Relationship to Patient**

_____ _____ _____

Witness **Date** **Time**