

# 1960 Digital Imaging

Also serving

## CYPRESS CREEK PHYSICIAN management

### Conditions of Service

PATIENT \_\_\_\_\_ DOB \_\_\_\_\_ ACCT# \_\_\_\_\_

#### Assignment of Benefits

I, or authorized representative/legal guardian acting on behalf of the patient hereby authorize filing of claims, payment of insurance benefits, and appealing claims directly to 1960 Digital Imaging and/or Cypress Creek Physician Management (the "provider") for services rendered. I am financially responsible and will pay for charges not covered by my insurance plan.

#### Financial Agreement and Statement of Responsibility

For and in consideration of services rendered or to be rendered by the provider, I agree to pay said provider for all services and charges. I understand that I am responsible for any health insurance deductibles, coinsurance, and non-covered charges. I understand that Cypress Creek Physician Management is not a participating provider of any insurance plan. It is the policy of Cypress Creek Physician Management to honor in-network benefits in regards to a patient's financial responsibility. **I understand payment in full is due at the time services are rendered or payment arrangements are to be made before my appointment. I understand that the amount quoted by the facility as being my responsibility is an estimate only and any patient balance remaining after my insurance has processed my claim will be billed to me and due within 30 days.**

I understand that it is my responsibility to inform the office with a minimum of a 24 hour advance notification if I am unable to make my appointment. I understand that I will be charged a fee for not giving proper notification.

X _____	
Patient/Guarantor Signature	Date

#### Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment or examination at the facility.

X _____	
Patient/Guarantor Signature	Date

#### Acknowledgement of Review of Privacy Practices

I, the undersigned, have reviewed the Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Privacy Practices.

#### Release of Patient Healthcare Information

I hereby authorize the facility and any subcontractor of, **to release or obtain** patient healthcare information, including but not limited to reports, prior films/images, test results, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the purpose of providing current continuum of care including to facilitate reimbursement by a health benefit plan or third party payer, including but not limited to, my insurance carrier, Medicare, Medicaid, and any other payer or agency.

#### Physician Ownership Disclosure

This is to inform you that your physician may or may not have an investment interest in the facility or pharmacy you are referred to. This information is being provided to you to help you make an informed decision about your healthcare. Should you be referred to a facility or pharmacy at any time and you prefer to use a different provider, you will be advised of alternatives. You will not be treated differently by you physician, physician's staff or the facility if you chose to choose a different facility.

X _____	
Patient/Guarantor Signature	Date

Do you have an advanced directive (living will)? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please bring a copy into our office for our files.

If no, and you would like information on an advanced directive, please speak with your physician.

The above authorizations are valid unless you revoke them in writing.