LISA A. DAVIS M.D., P.A.

PATIENT/CLIENT NAME: _____

SOCIAL SECURITY: _____

DATE OF BIRTH: _____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, as the patient (or the patient's duty authorized representative) and do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments and transfers to other facilities considered necessary or advisable in the judgment of the attending physicians, his/her assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed in this facility. I authorize **Lisa A Davis, M.D.,P.A.** or members of its attending staff to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, specimens and I certify by my signature that I understand and accept its contents, expect as noted.

FINANCIAL RESPONSIBILITY STATEMENT

Its is the policy of **Lisa A Davis, M.D. P.A**. to bill your insurance carrier as a courtesy to you, even though you may be considered responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the applicable balance will then by due in full from you. Unless your insurance company has a contract with Dr Davis to pay based on a specific negotiated fee schedule, you may be held responsible for any difference remaining between the insurance payment and the total charges. We also require that arrangements for payments of your estimated share be made today. If your insurance carrier in excess of the balance of your account subsequently makes any payment, we will promptly refund the credit. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Lisa A Davis MD,PA.**

However, if you are an HMO enrollee, the above statements only apply to your applicable co-pay and/or any other non-covered charge that you have agreed to be responsible for in advance of treatment. You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such default and upon referral to a collection agency or attorney by **Lisa A Davis MD PA.** you will be responsible for all costs of collecting monies owed including court costs, collecting agency fees and attorney fees. You also understand that you are responsible for keeping **Dr Davis** advised of any address changes. If any correspondence is returned, you understand that the account will by considered in default and will be turned over for collection immediately. The above information has bee read and your signature on the front side of this form signifies that you understand your responsibilities for the payment of you account.

RELEASE OF INFORMATION

I hereby authorize Dr Davis MD to release information to my insurer(s), their agent(s), including employer, if work related injury), about my injury or disability, medical condition, evaluation, treatment, work history or any and all medical information as may be necessary for payment of my hospital and medical claims, except as otherwise provided by applicable State or Federal laws. This release also allows information to be release for utilization review and financial audits or for the purpose of evaluation, treatment, and/or rehabilitation. This may include all reports and others contained in the medical record pertaining to the medical condition or injury for which I have sought treatment. In addition, this release authorizes Dr Davis, MD to release my records to any referred physicians for purpose of continued medical care. This will include all pertinent clinical notes, diagnostic test, and personal information. Also, any medical information returned from referral physicians used for Case Management purposes can by released to the above listed entities. I understand that this authorization may be revoked by me at anytime and that it is valid for a period which is consistent with the Medical Records Policy of **Lisa A Davis MD, PA** and its personnel are hereby release from all legal responsibility for such release of information as described above. A photocopy of this document shall be considered to be as valid as the original.

BENEFIT ASSIGNMENT

I hereby assign all medical and/or surgical benefits to include major benefits to which I am entitled, including Medicare, private insurance and any other health plans to **Lisa A Davis MD.** A photocopy of this assignment is to be considered as valid as the original. Your signature below signifies that you read and acknowledge the policies explained on both sides of this form regarding 1) Release of information, 2) Benefit assignment, 3) Consent for treatment and 4) the financial responsibility statement.

_____ _____

Patient or Responsible Party Date

_____ _____

Lisa A Davis MD PA Representative Date