Scheduling / 704-671-5969 Fax / 704-671-7755

SPECIALISTS OF THE CAROLINAS

620 Summit Crossing Place, Gastonia
209 Park Street, Suite 300, Belmont

Consent Form

Authorization for Treatment and Assignment of Benefits

CONSENT TO ADMISSION, EXAMINATION, & TREATMENT: I, whether signed as the patient or as the personal representative for the patient, hereby consent to treatment/admission and grant permission for the examination, testing, treatment, and photographs for treatment evaluations by MRISC and the physician(s) providing care. For my protection and the protection of the people who provide health care for me, I consent to testing for communicable and infectious diseases. It is recognized that most physicians furnishing services to the patient (including the Emergency Services Physician, Radiologist, Pathologist, Anesthesiologist, and the like) are INDEPENDENT CONTRACTORS and are neither employees nor agents of MRISC.

FINANCIAL OBLIGATION: I, in consideration of the services to be rendered to me, agree to pay the account at MRISC, and/or physicians providing services, in accordance with current charges. I understand that the account is due and payable at the time service is rendered. Any additional unpaid balance will be billed (unless I make other appropriate arrangements). Should the account be referred to collections whether it is a collection agency, attorney or other agent, Provider reserves the right to refer my outstanding balance to collections, and I agree to be responsible to pay the reasonable costs and fees of collection. Any amounts collected will be applied first to cost of collection, then to outstanding interest and then to principal.

RELEASE OF INFORMATION: I authorize MRISC and physicians providing services, to disclose by voice, fax, electronic or written methods, all or any part of my medical record to any person, corporation, or third party which is or may be liable under a contract with MRISC, or to myself, to a family member, or to an employer of myself or personal representative related to claims or services rendered. MRISC is authorized to obtain from or share with other agencies or institutions relevant medical or social information necessary to seek assistance, such as transfer to another healthcare facility or provider.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign to MRISC all benefits to which I may be entitled by virtue of insurance or public funding and authorize MRISC to file claims therefore. Further, I hereby assign benefits payable for the service of Physicians to the Physician or organization furnishing the service and authorize the Physician to file claims.

APPLICATION OF CREDIT BALANCE: Credit balances which occur in my favor on this account for whatever reason may be applied by MRISC to reduce any other outstanding account with MRISC or any facility owned by MRISC for which I am responsible before refund of any balance remaining.

PERSONAL VALUABLES: I understand and agreed that it is my responsibility for the safekeeping of money and valuables and MRISC shall not be liable for loss or damage to any money, jewelry, glasses, dentures, documents, and coats or other articles of value, and shall not be liable for loss of damage to any other personal property.

I, AS THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE, HAVE READ THE FOREGOING, ACKNOWLEDGE AND UNDERSTAND ALL TERMS, AND HAVE RECEIVED A COPY OF SAME UPON REQUEST.

Signed _____ Date _____
(Patient or Personal Representative)

Witnessed_____

Does the patient have a living will? [ ]Yes [ ]No Does the patient have Healthcare Power of Attorney? [ ]Yes [ ]No

Does the patient want information about Living Wills and/or Healthcare Power of Attorney? [ ]Yes [ ]No