OCALA HEALTH HEART & LUNG SURGERY

PATIENT CONSENT FOR TREATMENT & FINANCIAL COMMUNICATIONS

Patient Name:_____

Date of Birth:_____

_____(Patient/Representative initials) **Consent for Treatment.**

This consent provides Ocala Health Heart & Lung Surgery with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; Consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

_____(Patient/Representative initials) **Financial Agreement.**

I acknowledge, that as a courtesy, Ocala Health Heart & Lung Surgery

- May bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

_____(Patient/Representative initials) **Third Party Collection**.

I acknowledge that Ocala Health Heart & Lung Surgery may utilize the services of a third party business associate or affiliated entity as a central billing office ("CBO Servicer") for medical account billing and servicing.

_____(Patient/Representative initials) **Assignment of Benefits.**

I hereby assign to Ocala Health Heart & Lung Surgery any insurance or other third-party benefits available for health care services provided to me. I understand Ocala Health Heart & Lung Surgery has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Ocala Health Heart & Lung Surgery, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

_____(Patient/Representative initials) **Medicare Patient Certification and Assignment of Benefit.**

I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Ocala Health Heart & Lung Surgery by the Medicare or Medicaid program.

_____(Patient/Representative initials) **Consent to Telephone Calls for Financial Communications.**

I agree that, in order for Ocala Health Heart & Lung Surgery, or Central Billing Office (CBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Ocala Health Heart & Lung Surgery or CBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Ocala Health Heart & Lung Surgery or CBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I certify that I have read and understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature: _____Date_____

If you are not the Patient, please identify your Relationship to the Patient: _____

A photocopy of this consent shall be considered as valid as the original.