CARE AUTHORIZATION / HIPAA / INFORMATION RELEASE / BENEFIT ASSIGNMENT

CONSENT TO TREAT / HIPAA / NOTICE OF PRIVACY PRACTICES

The term "health care provider(s)" in this document means Good Shepherd Medical Group (GSMG), its agents, employees, members of the medical staff, their agents, employees, and other health care practitioners who provide care to patients.
I understand that as part of my health care, GSMG originates and maintains health care records describing my health history, symptoms, examinations, test results, diagnoses, and treatment plans (previous or future). I understand that this information serves as:

1. Basis for planning my care and treatment
2. A means of communication among health professionals who contribute to my care
3. A source of information for applying my diagnosis and surgical information to my bill
4. Information used to file my claim with the insurance company (procedure and diagnosis)
5. Means by which a third-party payer can verify that billed services were actually provided
6. A tool for routine health care functions such as assessing quality, reviewing the competence of healthcare professionals.

I understand that I have the option of receiving the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that GSMG reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment, or health care operation and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that GSMG has already taken action on my behalf. Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing, and procedures as are deemed necessary in the course of my care.

☐ No restrictions

☐ I request the following restrictions to the use or disclosure of my health information:
(If additional room is needed please use back of form)

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RELEASE OF INFORMATION

Information about me necessary to substantiate my insurance claims may be released by the health care provider involved in my care.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those health care providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits to any policies of insurance to those health care providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance. If such amounts due to the health care providers are not paid after reasonable notice, that account shall be deemed delinquent and a service charge shall be added to the amount due. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default, including court costs and reasonable attorney's fees. If debt is assigned to a third party for collection, I agree to be responsible for collection of fees and interest due on amounts in default.

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION & RELEASE OF INFORMATION

I request that payment of authorized medical benefits be made either to me or on my behalf to GSMG for any services furnished me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits or the benefits payable for related services.
I understand my signature requests that payment be made and I authorize release of medical information necessary to pay the claim. If other health insurance is indicated on item 9 of the CMS-1500 claim form or elsewhere on the approved claim form or electronically submitted claim, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

RECEIPT OF GSMG POLICIES AND PROCEDURES

My signature states that I have received, read and understand GSMG's policies, and that violation of these policies could result in dismissal from the practice for me and/or my family members.

________________________, __________		______________________	______________
Patient Name (Please Print)	Date of Birth	Relationship to patient	Today's Date

______________________________	______________________	______________
Signature of Patient or Legal Representative	Witness	Today's Date