Baton Rouge General Physicians

Patient Label or Information

Name:_____

Date of Service/Admit:_____/_____/_____

Account Number:_____

Treatment Authorization, Financial Assignment and Acknowledgements

Financial Responsibility

This is to certify that the information provided to Baton Rouge General Physicians ("Provider") is true and correct to the best of my knowledge and belief. In consideration of the services rendered to the patient named below, I/we assume responsibility for and guarantee the payment of all Provider charges in accordance with the Provider's then current rate. Total charges are payable when rendered. I/we also agree that, except as provided by law, I/we shall be responsible for the payment of any Provider charges which, for any reason, are not paid by any payer or insurance company. In the event this account is rendered delinquent and requires legal action to resolve payment, I/we agree to pay, in addition to the principal sum due, a fee of twenty five (25%) of the amount due on the account to cover attorney fees and expenses incurred by this Practice.

Consent for Treatment

I/we agree and consent to all procedures, medical treatments, and photographs, video tapes, digital, or other images deemed necessary by the patient's physician(s). I/we acknowledge that there is no guarantee, express or implied, as to the results of procedures and medical treatments performed. As a patient of the Provider, part or all of your care may be rendered by other practitioners or practitioners in training (physicians, nurses, technicians, etc.) under the supervision of the appropriate medical and/or allied staff.

Medical Release and Assignment of Insurance Benefits

I/we authorize Baton Rouge General Physicians to release any and all medical records, including diagnoses related to alcohol/drug abuse, mental disorders, HIV/AIDS status and related illnesses and billing information to the Social Security Administration, Medicare, Medicaid (or their various intermediaries), the patient's insurance companies, health maintenance organizations, workers compensation carriers, employers, alternate care facilities, or persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), including but not limited to _____, when such information is requested for payment, utilization review or coverage determination purposes. I/we understand that I/we may revoke this consent at any time, except in instances where a particular action depends upon the consent remaining in effect, including, but not limited to securing full payment of the account(s). This authorization shall remain in effect until revoked or another Treatment Authorization, Financial Assignment and Acknowledgements form is signed. I/we further authorize any such payer or insurance company to pay directly to the Provider all benefits due and payable as a result of services rendered by the Provider. A photocopy of this Treatment Authorization, Financial Assignment and Acknowledgements shall serve as an original.

Quality Survey

I/we understand and agree that the Provider or a contracted agency may contact me/us to discuss information relative to quality concerns.

Patient Rights and Responsibilities

I/we understand that as a patient, a copy of the Patient Rights and Responsibilities is available upon request.

Notice of Privacy Practices

I/we, individually or on behalf of the patient, authorize the Provider to use and disclose my health information as required for treatment, payment, and healthcare operations as described in the Provider's Notice of Privacy Practices. I hereby acknowledge that I was offered a copy of the Provider's Notice of Privacy Practices on the date written below.

_____ _____ _____/_____/_____

Patient's Signature (if unable to sign, then by Legal Guardian or Next of Kin) | Relationship to Patient | Date

_____ _____ _____/_____/_____

Guarantor/Policy Holder | Relationship to Patient | Date

_____ _____

Witness | Witness