Consent for Treatment

Authorization for Treatment, release of medical information and assignment of insurance benefits.

Authorization to Release: I hereby authorize St. Dominic Medical Associates and any physician providing treatment to me, to release or disclose to insurance companies and/or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Authorization to Release: Work/School excuse to my employer / school official should the need arise.

Authorization to Pay Insurance Benefits: I hereby assign payment directly to St. Dominic Medical Associates of all insurance and similar benefits otherwise payable to me by virtue of medical treatment provided by St. Dominic Medical Associates, but not to exceed St. Dominic Medical Associates regular charges for medical treatment. I understand I am financially responsible for charges not covered by insurance, and I hereby agree to be responsible for all charges incurred, regardless of the status of medical insurances or similar benefits.

Consent for Treatment: The undersigned patient or patient's representative aurhorize(s) the physician(s) on duty at St. Dominic Medical Associates to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patient identified below while a patient of St. Dominic Medical Associates. This treatment may require diagnostic procedures including but not limited to laboratory tests, drawing blood for those tests, x-rays and electrocardiograms.

Consent for Retirement of X-rays Film and Graphic Data: The undersigned authorizes the clinic to retire x-ray films and any other graphic data, which may be generated seven years after they are generated if the written and signed findings of a radiologist or other professional who has interpreted the x-ray or graphic data is maintained in the medical record. Exception: Patient is unable to consent because: ______________________

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Consent for Blood Sample: The undersigned agrees to submit a blood sample in the event of a blood exposure to an employee during treatment to be used for screening of blood bourne pathogens or diseases.

Payment Terms: Late Fee: I understand that payment in full is due on the date of treatment for all services provided and I agree to pay all charges for the patient named below. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance. On any balance remaining more than fifteen (15) days after the date of service, I also agree to pay a late fee that is the GREATER of five dollars ($5.00) or four percent (4%) of the unpaid balance.

Valuables: The undersigned hereby releases the St. Dominic Medical Associates and / or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his / her possession or that may be brought to him / her by other persons while on the premises of the St. Dominic Medical Associates.

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Patient's Printed Name

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Signature of Patient / Guardian (If a minor) Date