Covenant Medical Center, P.C.

(PLEASE PRINT CLEARLY)

ACKNOWLEDGEMENT & AUTHORIZATIONS

PLEASE READ CAREFULLY: All charges or co-payments, if applicable, are due at the time of services. The patient is responsible for all fees, regardless of insurance coverage unless the services are for properly authorized workmen's compensation, auto injuryor for services covered under a contractual agreement between this Medical Practice and your insurance carrier. I understand that I need to notify Covenant Medical Center, P.C. of tests or other treatments that may not be covered by my insurance policy. I realize that I am responsible for fees that are not covered by my insurance carrier. If hospitalization is indicated, the patient is responsible for ensuring Covenant Medical Center, P.C is informed of the necessary pre-certification requirements.

AUTHORIZATION TO RELEASE LAB AND DIAGNOSTIC TEST RESULTS: I understand that Covenant Medical Center's policy is to notify patients of any abnormal labs or diagnostic test results. We will notify you as soon as possible. I indicate below which results may be released and to whom that information may be released. (You may choose more than one option).

□ Give my results to me personally. My daytime phone number is _____. If you are not available to speak to us, we will leave a message to call our office).

If you cannot reach me personally, I authorize Covenant Medical Center to release my results to another person specifically:

Name: _____ Relationship: _____ Number: _____

□ If my results are benign (or within normal limits), you may leave my results on my answering machine at (check all that apply):

□Home _____ □ Work _____ □Cell/ Other _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize Covenant Medical Center to release all information necessary to secure payment, transmit and process claims electronically or through any other reasonable and customary means, including, but not limited to Medicare.

CONSENT TO OBTAIN MEDICAL RECORDS: I authorize Covenant Medical Center to obtain medical records from any other physician or medical facility necessary in the course of my treatment & continued primary care.

CONSENT FOR TREATMENT: I voluntarily consent to my treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures (including, but not limited to the use of lab and radiographic studies) as ordered by my attending physician. I have read this consent, and I am aware of its contents and fully understand the same. I acknowledge that no assurance or promises have been given to me concerning the results, which may be obtained by such treatments and procedures hereby, affirmed by the signature of the undersigned.

HIPPA COMPLIANCE NOTICE: I hereby acknowledge that I have read the COVENANT MEDICAL CENTER, P.C. - NOTICE OF PRIVACY PRACTICES that describes how information about me may be used and disclosed and how I may obtain access to this information. Furthermore, I acknowledge that I understand these policies and have received a personal copy of this information for my records. Copies are available at our office and online. COVENANT MEDICAL CENTER, P.C. will abide by all HIPPA regulations regarding privacy and confidentiality as outlined in our NOTICE OF PRIVACY PRACTICES

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE AND VOLUNTARILY AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Patient Name: _____

Guardian Name : _____
(If other than patient)

Patient/Guardian Signature: _____

Date: _____