Richmond Family Medicine Associates

Comprehensive Care for Your Entire Family

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DR. KASEY EIDSON, MD, PHD

Consent to Treatment and Financial Responsibility Agreement

1. **Consent for Medical Care.** The Undersigned, whether as patient or as agent, consents to the following:
   A. All initiation of care, consultation, treatment, and procedures to be performed. The treatment and procedures may include, but are not limited to, laboratory tests, injections, medical treatments or procedures, or other services rendered under the general and special instructions of the patient's provider.
   B. Allow the patient's prescription medication history to be obtained from external electronic sources.
2. **General Risks.** The Undersigned, whether as patient or as agent, understands that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. No guarantees can or have been made regarding the results of examination, procedures, or treatment.
3. **Release of Information.** The Undersigned, whether as patient or as agent, authorizes the following:
   A. Richmond Family Medicine Associates (RFMA) may disclose all or portions of the patient's medical record to any person or entity or their agents who may be liable to pay for all or a portion of the charges. RMFA's authority shall include but is not limited to release of the patient's diagnosis, surgical procedure, plan of care, and benefits by telephone at the time of appointment check-in or during or after the appointment. The entities to whom the information may be released shall include but not be limited to insurance companies, health maintenance organizations, or government or other payors or their agents, such as utilization review, rehabilitation, or auditing agencies.
   B. Gives consent to RFMA and its respective subsidiaries, affiliates, and vendors, to contact the Undersigned at the number provided using any means of communication, including, but not limited to, calls placed to a cellular phone using an automated dialing device and calls using prerecorded messages and/or SMS text messages, regarding any current or future accounts, outstanding balances, or payments owed to RFMA or its respective subsidiaries and affiliates even if the Undersigned will be charged by his or her service provider(s) for receiving such communications. The Undersigned understands he or she will be provided the option to update communication preferences during the servicing of accounts and will notify RFMA if he or she wishes to revoke this method of notification.
4. **Notice of Privacy Practices.** The Undersigned, whether as patient or as agent, acknowledges that the law requires that RFMA maintain the privacy of the patient's Protected Health Information and that RFMA provide a notice of legal duties and privacy policies with respect to protected health information. By signing below, the Undersigned acknowledges that he or she has received a copy of our Notice of Privacy Practices.

5. **Patient Portion Due at Time of Service.** The Undersigned, whether as patient or as agent, acknowledges all co-payments must be paid at time of service. This arrangement is part of the patient's contract with his or her insurance company.
6. **Insurance and Claims Submission.** The Undersigned, whether as patient or as agent, understands RFMA will submit insurance claims to most insurance companies; however, if RFMA does not participate with the patient's insurance plan, it will be the responsibility of the Undersigned to pay-in-full at time of service. The Undersigned should be aware that some or all the services may be non-covered by insurers, and many insurance companies require pre-authorization for various procedures. RFMA will assist in obtaining the necessary pre-authorizations when needed; however, it is the responsibility of the Undersigned to determine if the patient's insurance company requires one. Failure to obtain the necessary pre-authorization or second opinion may result in a reduction or denial of benefits by the insurance company, which would result in the requirement of the Undersigned to pay the full amount due. For employer-requested services, RFMA will confirm pre-authorization and guarantee of payment prior to the service being rendered.
7. **Assignment of Insurance Benefits.** If the patient's care is covered by insurance, the Undersigned agrees the insurance company is to pay RMFA directly for the patient's care. The person signing this form, whether he or she is the patient or signing for the patient, authorizes direct payment to RMFA and/or the physicians of any insurance benefits, settlements, or awards otherwise payable for this outpatient service at a rate not to exceed the respective charges of RMFA. The Undersigned understands he or she is financially responsible for charges not paid by insurance or any other third-party payor.
8. **Promise to Pay Account.** The Undersigned agrees that he or she will pay for the care the patient receives. The person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the account charges in accordance with the rates and polices of RFMA. The Undersigned also agrees that RFMA may assess interest on any unpaid balance at a rate not to exceed the maximum statutory amount per year.
9. **Guarantee of Account.** The Undersigned understands that RFMA must be paid for the care the patient receives. The Undersigned may expect that someone else is going to pay for the patient's care, as there may be insurance coverage, or the patient may have been injured due to some else's negligence, or there may be other circumstances; however, the Undersigned agrees to be personally-responsible for paying for the care received. Even if the Undersigned believes another party is obligated to pay for the care, he or she still agrees to personally guarantee RFMA will be paid for the care the patient receives. Therefore, the person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the charges in accordance with the rates and policies of RFMA. He or she agrees that RFMA may assess interest on any unpaid balance at a rate not to exceed the maximum statutory allowable interest rate per year.
10. **Minor Patients.** The Undersigned understands that the parent or guardian accompanying a minor is responsible for payment regardless of legal arrangements. An unaccompanied minor will not be seen without a minor consent form signed by the parent or guardian, and the minor must bring his or her co-payment or patient portion due at the time of service.

Patient, Parent, Guardian, Agent Name: (SIGNATURE)

_____ **Date:** _____

Patient, Parent, Guardian, Agent Name: (PRINT)

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