Meridian Health Services Consent for Treatment Form

AUTHORIZATION FOR TREATMENT: I hereby authorize provider to perform tests/services as deemed necessary and ordered by my provider.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize provider to release any such medical information from my record to my health insurance companies as may be necessary for the completion of any health insurance claim.

MEDICARE/MEDICAID PATIENTS: The execution of this document hereby serves as a request for payment of authorized government benefits on behalf of the patient named for any services furnished by or in Meridian Health Services to the provider accepting assignment. I (the patient/guarantor) certify(s) that the information given by me (the patient/guarantor) in applying for payment under Title XVIII and Title XIX of The Social Security Act is correct. I authorize any holder of medical or other information about me to release to The Social Security Administration or its intermediaries or carriers only such information needed for this or a related Medicare/Medicaid claim. I (the patient/guarantor) also authorize the release of medical and related information about my treatment to the peer review organization responsible for reviewing the medical care furnished me by your institution. I acknowledge that to the best of my ability I have answered the appropriate questions to determine if Medicare is Primary or secondary payor for this claim.

PRIVACY: I acknowledge that Provider Offices of Meridian Health Services have provided or offered a copy of a NOTICE OF PRIVACY PRACTICES as part of the Health Insurance Portability and Accountability Act (HIPAA) today or during a past registration.

FINANCIAL RESPONSIBILITY: I understand and agree that I am responsible for complete payment of either: the applicable deductible and/or co-payment amounts required under the terms of my insurance agreement or Charge Master rates. I further agreed that in the event of non-payment of this account, Meridian Health Services may take actions to enforce payment on this account, including sending this account to a collection agency, reporting this account to a credit bureau, and filing a lawsuit. In the event legal action is required in order to enforce payment on this account, I agree to pay all court costs, expenses, attorney fees, and other costs incurred or expended as a result of such proceedings.

I agree, in order for us to service your account and to collect any amounts I may owe, that we may contact me by telephone at any telephone number associated with your accounts, including wireless numbers, which could result in charges to me. Meridian Health Services may also contact me by sending text message or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automated dialing device.

CONSENT FOR BLOODBORNE INFECTIOUS DISEASE TESTING: I authorize the Meridian Health Services to test for blood borne infectious diseases, including but not limited to, hepatitis, and human immunodeficiency virus, if ordered by a physician, in the event one of my healthcare providers has an exposure to my blood or body fluid.

ELECTRONIC PRESCRIBING: I hereby authorize provider to obtain medication history and drug plan coverage as deemed necessary by my provider.

_____ _____ _____

Signature of patient, guarantor, legal guardian, Closest relative | Relationship if other than patient | Date

_____ _____ **Expiration Date: _____**

Witness Signature | Date

PATIENT LABEL