Lake Country Family Medicine

Authorization Form

Date: _____

Patient Name: _____ DOB: _____

1. Consent to Treat: The undersigned consents to any examination or medical treatment, and/or services rendered to patient by the physician/provider or their associates, which in the judgment of such practitioners are advisable during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science and no guarantees and be given by anyone as to the results that will attained from any diagnosis or treatment.

2. Assignment of benefits/insurance requirements: In consideration of goods and services rendered, I irrevocably assign and transfer to Lake Country Family Medicine to file a claim on my behalf as the same does not impose any contractual obligations upon Lake Country Family Medicine in that I remain responsible for instituting suit within that applicable statute of limitations. I authorize Lake Country Family Medicine to appeal any denial. It is agreed that any condition, including, but not limited to, precertification, pre-authorization, or second opinions shall remain the sole responsibility for patient and/or the patient's family, legal guardian, representative or agent. I authorize the payor listed here in and any other payors to release any and all information requested and/or related to my claim(s) to Lake Country Family Medicine.

3. Financial responsibility: It is agreed that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges use for services rendered, and I agree that all amounts are due upon requested and are payable to Lake Country Family Medicine, and agree to pay all charges incurred. If not a member of an accepted insurance group, fees for services provided must be paid at time they are rendered. It is agreed that should this amount be delinquent and it becomes necessary for the account to be render to any attorney or collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all collection expenses. I agreed that if this account results in a credit balance, the credit amount will be applied to any outstanding account, either current or bad debt.

The undersigned certifies that he/she has read and accepted this authorization form is that patient or parent(s) or legally authorized representative of the patient(s).

_____ _____

Signature of patient or patient's legally authorized representative *Relationship*