CLIENT'S CONSENT TO EXCHANGE INFORMATION

PRIMARY CARE PHYSICIAN

Insurance plans and managed care organizations encourage the exchange of information between this office and your Physician/ Therapist in order to coordinate medical and psychiatric care (if applicable). ***Please make a selection below.***

☐ I give consent for information regarding my treatment to be shared with my Referring Physician/ Therapist as follows;

Name of Referring Physician: ______ Phone: ______

Located at: ______

Name of Therapist: ______ Phone: ______

Located at: ______

INSURANCE CLAIMS PAYMENT

I authorize the release of medical record information or excerpts thereof, to any insurance company or third party payer for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible to pay Community Medical Center (CMC) its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patient's responsibility to obtain any prior authorization or doctor's referral. I understand that failure to meet this requirement may result in a significant loss of benefits. I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to CMC, and direct that payment of proceeds be made directly to CMC.

We reserve your appointment time for you, we may charge a fee up to and including our full normal fee, for missed appointments not cancelled at least 24 hours in advance.

My signature below represents that I have read and understand the terms and statements above.

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

Patient's Signature	Date	Parent/Guardian's Signature	Date

☐ I have witnessed the completion of this authorization form.

Third Party Access

I authorize CMC to disclose current healthcare information with the family/others listed below.

Spouse	Phone	Parent	Phone

Sibling	Phone	Other	Phone

Patient Signature	Date	Employee Signature	Date