CONSENT FORM

Authorization for Treatment: I present myself for person for whom I am guardian for diagnostic treatment and other services that are deemed necessary by my physician. I am aware that medicine is not an exact science and I understand that there are no guarantees regarding the outcome of my treatment.

Authorization for Release of Information: I authorize Calvary Medical Clinic PA to disclose all parts of my medical record (including psychiatric, drug and alcohol abuse conditions, and AIDS related conditions), to insurance and government agencies, the patients or other agencies which review Workman's Compensation, Utilization review which is under agreement with the patient's employer of payment source. This same information may be disclosed to any healthcare organization or agency which will assist in the continuance of my care. I understand that I may revoke this authorization at any time.

Medicare/Medicaid Patients Certification: I certify that information given by me in applying payment to be made under Title XVII and XIX of the Social Security Act is correct. I request payment to be made directly to the provider of services on my behalf and I authorize Calvary Medical Clinic, PA to transfer this to any unpaid balance due to Calvary Medical Clinic, PA.

Assignment of Benefits: I hereby authorize payment directly to Calvary Medical Clinic, PA by my insurance carrier(s). In the event that payment is received from more than one carrier creating an overpayment, I understand that the overpayment will be sent back to the appropriate party. In the event that the overpayment is due from my part, I authorize Calvary Medical Clinic, PA to transfer this to any unpaid balance due to Calvary Medical Clinic, PA.

Payment of Services: I understand that I am financially responsible for all charges and fees related to the treatment and services rendered to me by my physician. I further understand that payment is expected at the time of services for each office visit to include co-payments, deductibles, and any other services not covered by my insurance. I will inform Calvary Medical Clinic, PA and make arrangements to pay off my balance due in a timely manner.

Insurance: If you are enrolled in one of the manage care/insurance plans with which Calvary Medical Clinic, PA participates, we will file your insurance as a service to you. If we are not a member of your insurance plan, you are responsible for a larger percentage of the bill. If our office does not hear from your insurance company in 30 days, we request your help in contacting your insurance company to resolve the payment delay. Understand that the insurance plan is a contract with you and your insurance company. We must hold you responsible for any balance due.

Against Medical Advice: I understand that the doctor is acting in my best interest and in good faith. Therefore I do not hold the doctor or Calvary Medical Clinic, PA responsible for consequences which may result from my refusing treatment at any time.
Outside Referral of Labs and X-rays: I understand that at times my private physician may refer me to an outside source for outpatient services. I further understand that Calvary Medical Clinic, PA is performing these services for my convenience. Therefore I do not hold Calvary Medical Clinic, PA or its agents (physicians) liable with respect to follow up results that have been ordered by outside physicians. I understand that Calvary Medical Clinic, PA will make every attempt possible to forward the results to my physician.

I CERTIFY THAT I HAVE READ AND UNDERSTAND ALL OF THE ABOVE INFORMATION.

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SIGNATURE DATE