Mark J. Pamer, D.O., LLC

Patient Name: _____

I hereby give consent for the necessary medical treatment for the above named patient for whom I am legally responsible. This consent for treatment includes medical care provided today and those of subsequent appointments.

Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of Mark J. Pamer, D.O., LLC (the **Practice)**, are entitled to the greatest degree of privacy possible. The release of medical information to any insurance carrier, other entities directly associated with the **Practice**, your primary care provider and/or referral physician in connection with treatment is authorized. This office will strive to ensure that patient information is used only for authorized purposes as agreed by the patient. No other disclosures will be made without written authorization from the patient or guardian. Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours and to make comments to the same. All requests must be made in writing.

Assignment of Benefits

I hereby authorize and assign to the **Practice** all payments and/or insurance benefits for services rendered. I agree to complete any additional forms which may be required by me in insurance plan for assignment of benefits. I hereby authorize the **Practice** to release medical information necessary to obtain payment.

Financial Responsibility

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at the **Practice**. It is my responsibility to know and understand my insurance policy. I am responsible for payment of any applicable deductible, copayment or coinsurance prior to the provision of services. I understand that by law, the deductible, copayment, and coinsurance cannot be waived. The **Practice** will provide me with an estimate of my total financial responsibility. I understand that this amount is only an estimate based on what my insurance plan may pay. In the event that fees exceed the amount of the estimate, I will be financially responsible for the balance. I understand that such payment is not contingent on any insurance, settlement or judgment payment. I further understand that such payment is not contingent on the results of any treatment. The **Practice** does not refund any payment for services rendered. The **Practice** will file a claim for payment with my insurance plan as a courtesy to me. If the insurance plan fails to pay the **Practice** in a timely manner for any reason, I understand that I will be responsible for prompt payment of all amounts owed to the **Practice**. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL AMOUNTS NOT COVERED BY THE INSURANCE PLAN(S).** I will receive a statement once a month if I have a balance owing. Failure to pay a balance by the third billing statement will result in my account being turned over to the collection process. **SHOULD MY ACCOUNT BE REFERRED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION, THEN I WILL PAY ALL COSTS OF COLLECTION, INCLUDING A REASONABLE ATTORNEY'S FEE.**

Authorization for treatment/Release of information

In connection with the medical services that I am receiving from the **Practice**, I hereby authorize the **Practice** to disclose any/all information concerning my medical condition and treatment (including, but not limited to, super confidential information concerning sexually transmitted diseases, mental health, chemical dependence, or other such information), including copies of applicable hospital and medical records, to:

A. Any third-party payer covering the medical services with the patient;
B. Other healthcare professionals and institutions involved in the delivery of healthcare;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employee and agents for the **Practice**, to the degree necessary to facilitate the provisions of Healthcare Services and provide for such payment of services;
E. Pharmacies; and
F. As otherwise required by law

In each case, the **Practice** shall take reasonable steps to ensure that only the minimum necessary information is disclosed accordance with the above. I have read and understand the above. I further understand that I have been given access to the physician's privacy notice and that copy of which was available for my taking. I have had the opportunity to place special restrictions upon the consent hereby given. I further understand that special requests for restrictions must be submitted to the practice in writing and must be reviewed and approved by the designated Privacy Officer. I also hereby authorize the disclosure of personal health information to the individuals listed below and via answering machine.

To the following individuals:

_____ Relationship _____

_____ Relationship _____

I hereby acknowledge that I am responsible, and it is my best medical interest to attend any scheduled appointments and/or follow-up appointments with the **Practice**, as recommended by my physician. I further understand that if my physician orders/recommend outpatient diagnostic imaging testing, a sleep study, PFTs, or laboratory testing, it is because he/she feels it is a my best interest. Finally, I understand that **THE PRACTICE HAS A NO-SHOW FEE IN EFFECT WHICH REQUIRES 24 HOUR NOTICE IF I MUST CANCEL AN APPOINTMENT.** If I fail to abide by this policy, I will be responsible for charge of **$50 per occurrence**. This must be paid prior to seeing the **Practice** for any other appointments.

This consent is valid from the date executed until revoked in writing by the patient.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date