Patient Last Name: _____

First Name: _____

Date of Birth: _____

Patient MRN#: _____

Consent to Treatment and Financial Responsibility Agreement

1. **Consent for Medical Care:** The undersigned, whether as patient or as agent, consents to the following:
    a. All initiation of are, consultation, treatment, and procedures to be performed (including emergency treatment or services). The treatment and procedures may include, but are not limited to, laboratory tests, x-ray examinations, injections, medical or surgical treatments or procedures, anesthesia, or other services rendered under the general and special instructions of the patient's provider.
    b. Testing for HIV antibody (AIDS), hepatitis, or bloodborne pathogen should the healthcare worker have an exposure to the patient's blood or other body fluids.
    c. Transfer and transportation to another facility for further care as instructed by the patient's provider.
    d. Allow the patient's prescription medication history to be obtained from external electronic sources.
2. **General Risks.** The Undersigned, whether as patient or as agent, understands that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. No guarantees can or have been made regarding the results of examination, procedures, or treatment.
3. **Release of Information.** The Undersigned, whether as patient or as agent, authorizes the following:
    a. Project Recovery may disclose all or portions of the patient's medical record to any person or entity or their agents who may be liable to pay for all or a portion of the charges. Project Recovery authority shall include but is not limited to release of the patient's diagnosis, surgical procedure, plan of care, and benefits to telephone at the time of appointment check-in or during or after the appointment. The entities to whom the information may be released shall include but not be limited to insurance companies, health maintenance organizations, worker's compensation carriers, or government or other payors or their agents, such as utilization review, rehabilitation, or auditing agencies.
    b. Release of clinical information to providers and facilities for the purpose of continued health care.
    c. Gives consent to receive artificial, pre-recorded or auto-dialed calls from Project Recovery or its designated third parties to the designated cellular or residential telephone number(s) provided for the purpose of scheduling, telemarketing, debt collection, or other purposes. The patient or agent will notify Project Recovery if he or she wishes to revoke this method of notification.
4. **Notice of Privacy Practices.** The Undersigned, whether as patient or as agent, acknowledges that the law requires that Project Recovery maintain the privacy of the patient's Protected Health Information and that Project Recovery provide a notice of legal duties and privacy policies with respect to protected health information. By signing below, the Undersigned acknowledges that he or she has received a copy of our Notice of Privacy Practices.
5. **Patient Portion Due at Time of Service.** The Undersigned, whether as patient or as agent, acknowledges all co-payments must be paid at time of service. This arrangement is part of the patient's contract with his or her insurance company. For procedures, the Undersigned will be asked to pay a co-insurance and deductible. Upon request, an estimate or services will be given prior to the service being performed.
6. **Insurance and Claims Submission.** The Undersigned, whether as patient or as agent, understands that Project Recovery will submit insurance claims to most insurance companies; however, if Project Recovery does not participate with the patient's insurance plan, it will be the responsibility of the Undersigned to pay-in-full at time of service. The Undersigned, should be aware that some or all of the services may be non-covered by insurers, and many insurance companies require pre-authorization for various procedures. Project Recovery will assist in obtaining the necessary pre-authorizations when needed; however, it is the responsibility of the Undersigned to determine if the patient's insurance company requires one. Failure to obtain the necessary pre-authorization or second opinion may result in a reduction or denial of benefits by the insurance company, which would result in the

requirement of the Undersigned to pay the full amount due. For employer-requested services, Project Recovery reserves the right to confirm pre-authorization and guarantee of payment prior to the service being rendered.

7. **Assignment of Insurance Benefits.** If the patient's care is covered by insurance, the Undersigned agrees the insurance company is to pay Project Recovery directly for the patient's care. Additionally, certain physicians/Caregivers(e.g. Counselors) may participate in the patient's care at the clinic. The person signing this form, whether he or she is the patient or signing for the patient, authorizes direct payment to Project Recovery and/or the physicians of any insurance benefits, settlements, or awards otherwise payable for this outpatient service (including emergency services if rendered) at a rate not to exceed the respective charges of Project Recovery and/or the physicians. The Undersigned understands he or she is financially-responsible for charges not paid by insurance or any other third-party payor.
8. **Promise to Pay Account.** The Undersigned agrees that he or she will pay for the care the patient receives. The person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the account charges in accordance with the rates and policies of Project Recovery. If the patient is uninsured or has a large deductible, payment arrangements can be made with Project Recovery. The Undersigned also agrees that Project Recovery may assess interest on any unpaid balance at a rate not to exceed the maximum statutory amount per year.
9. **Guarantee of Account.** The Undersigned understands that Project Recovery must be paid for the care the patient receives. The Undersigned may expect that someone else is going to pay for the patient's care, as there may be insurance coverage, or there may be other circumstances; however, the Undersigned agrees to be personally-responsible for paying for the care received. Even if the Undersigned believes another party is obligated to pay for the care, he or she still agrees to personally guarantee Project Recovery will be paid for the care the patient receives. Therefore, the person signing this document, whether he or she is the patient or is signing for the patient, agrees that he or she personally obligates himself or herself to pay the charges in accordance with the rates and policies of Project Recovery. He or she agrees that Project Recovery may assess interest on any unpaid balance at a rate not to exceed the maximum statutory allowable interest rate per year.
10. **Minor Patients.** The Undersigned understands that the parent or guardian accompanying a minor is responsible for payment regardless of legal arrangements. An unaccompanied minor will not be seen without a minor consent form signed by the parent or guardian, and the minor must bring his or her co-payment or patient portion due at the time of service.

Patient, Parent, Guardian, Agent name (Signature):_____ Date: _____ Time: _____
Patient name (PRINT): _____

If other than the patient, indicate your relationship to the patient and print your name: _____
Witness (1) name PRINT and SIGN: _____ Date: _____ Time: _____
Witness (2) name PRINT and SIGN: _____ Date: _____ Time: _____
(2 witnesses needed for verbal consents only)