

# CENTRAL TEXAS MEDICAL ASSOCIATES

## Authorizations, Consents and Agreements

### CONSENT

**CONSENT TO TREATMENT:** As a patient at Central Texas Medical Associates, I consent to care and treatment only after the recommended treatment is explained to me. I understand that while a patient at Central Texas Medical Associates, I am under the care of my attending physician with support from other physicians including consulting physicians, and house staff. I also understand that radiologist, pathologists, and the like, are independent contractors and are not employees or agents of Central Texas Medical Associates.

INITIAL \_\_\_\_\_

### FINANCIAL

**FINANCIAL AGREEMENT:** The undersigned agrees, as patient or agent of the patient, that the patient is accepting financial responsibility for services rendered and is obligated to pay the account balance in full. If there is verifiable Medical Insurance Coverage or other verifiable financial coverage, a claim will be filed as a convenience to the patient. However, it remains the responsibility of the patient/guarantor to follow-up with his/her insurance company if the claim is not paid within 45 days. Pre-certification is the responsibility of the patient/guarantor and should be secured prior to services whenever possible, within policy limitations in case of emergencies. Payment for services not covered by the insurance or third party payer is the responsibility of the patient/guarantor. Our billing office will handle all self-pay portions after insurance payments. Should the account be referred to a collection agency, the undersigned may be assessed a collection fee and reasonable attorney fees and court costs.

INITIAL \_\_\_\_\_

### INSURANCE

**ASSIGNMENT OF BENEFITS:** I hereby authorize all insurance companies to pay direct to Central Texas Medical Associates. I understand that this order does not relieve me of my obligation to pay the account. Also, any deductibles and co-payments are my responsibility.

INITIAL \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION:** I hereby consent & authorize Central Texas Medical Associates and affiliates to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefits from my health insurance carrier.

INITIAL \_\_\_\_\_

**\*\*MEDICARE BENEFICIARIES ONLY:** I certify that the information given in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made. I understand that I am responsible for health insurance deductibles and coinsurance.

**MEDICARE SUPPLEMENTS:** I further authorize Central Texas Medical Associates to claim and receive benefits thru my Medicare supplement, \_\_\_\_\_.  
Name of Insurance Company/Companies

This authorization includes claims for Medigap benefits and shall remain in effect until and unless revoked in writing.

INITIAL \_\_\_\_\_

I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENT, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

\_\_\_\_\_  
Signature of Patient/Responsible party  
(Relationship)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient Account Number

\_\_\_\_\_  
Date