Patient Name: _____ **Account #** _____

RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS STATEMENT TO THE PHYSICIAN & MEDICAL GROUP

I hereby authorize the release of medical information by Modern Concepts Medical Group which may be necessary to file a claim with my insurance company. I also assign benefits for those services provided by Modern Concepts Medical Group, otherwise payable to me, to be paid to Modern Concepts Medical Group.

I understand that I am financially responsible for any balance not covered by my insurance carrier, including deductibles and insurance co-payments. A copy of this form and signature is as valid as the original.

If I have Medicare insurance coverage, I request that payment of authorized Medicare benefits be made to Modern Concepts Medical Group on my behalf for those services provided by the group. I also acknowledge that I may be responsible for any unmet portion of the $100 annual deductible imposed by Medicare. I also authorize any holder of medical information about me to be released to the Health Care Financing Administration upon their request.

If I have Medigap coverage, I request authorized Medigap benefits to be made on my behalf to Modern Concepts Medical Group for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable to related services.

I have been notified that any appointments not cancelled within 24 hours may be subject to a fee which will be due prior to my next visit.

I also authorize Modern Concepts Medical Group to obtain, based on the signature below, and pursuant to the Health Insurance Portability Accountability Act of 1996, any medical records from any hospital or institution that they may need for the purposes of settling a claim dispute or audit with any insurance company, including the Health Care Financing Administration (Medicare).

_____

Signature of Patient and/or Legal Guardian

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, the undersigned, hereby voluntarily consent to outpatient medical care for myself, or minor dependant, at Modern Concepts Medical Group encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician or practitioner.

In the case of a minor, I state that I am the legal guardian of this patient. I authorize Modern Concepts Medical Group, under my physicians direction, to render medical care even if I cannot be present.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the physician, nurse practitioner, or physicians' assistant and their assistants, including, medical assistants, technicians, or any other designees as is necessary in the practitioners judgment.

Additionally, I consent to the use or disclosure of my protected health information (PHI) by Modern Concepts Medical Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Modern Concepts Medical Group.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. A form will be provided upon request. Modern Concepts Medical Group is not required to agree to the restrictions that I may request. However, if Modern Concepts Medical Group agrees to a restriction that I request, the restriction is binding on Modern Concepts Medical Group.

I have the right to revoke this consent, in writing, at any time, except to the extent that Modern Concepts Medical Group has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Modern Concepts Medical Group Notice of Privacy Practices prior to signing this document. This Notice of Privacy Practices describes my rights and the duties of Modern Concepts Medical Group with respect to my protected health information.

_____ _____

Signature of Patient and/or Legal Guardian Date