

CONSENT FOR MEDICAL SERVICES AND FINANCIAL AGREEMENT

1. **MEDICAL CONSENT:** The undersigned consent to and authorize any medical treatment, examination, laboratory procedure, X-ray examination, taking of medical photographs, or hospital services that may be considered advisable or necessary for the patient in the judgment of the attending physicians.

2. **FINANCIAL AGREEMENT:** The undersigned agree, whether signing as a patient or as an agent, that in consideration of the services to be rendered to the patient, the undersigned shall have the obligation to pay the account of the patient with **Healthline Medical Group** in accordance with the regular rates and terms of **Healthline Medical Group** as in effect from time to time. Such account shall be due and payable at the time of discharge unless other arrangements are approved in writing prior to such time by **Healthline Medical Group**, which shall have sole discretion whether to approve other payment arrangement. If the patient's account is not paid when due, it shall bear interest from the due date at the maximum for the account of the patient on any deferred basis, and payment is not made when due, **Healthline Medical Group** shall have the immediate right to charge such sum to the credit cards of the undersigned listed hereon, the undersigned's signature(s) herein constituting complete authorization to **Healthline Medical Group** to charge such credit cards. If the patient's account is referred to a collection agency and/or an attorney for collection, the undersigned shall pay all attorney's fees for and costs of collection.

3. **MEDICARE: Patient's Certification, Authorization to Release Information, and Payment Request:** The undersigned certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related medicare claim. The undersigned request that payment of authorized benefits be made on the patient's behalf.

4. **RELEASE OF INFORMATION:** **Healthline Medical Group** may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to **Healthline Medical Group** or to the patient or to a family member or employer of the patients for all or part of **Healthline Medical Group** charges, including, but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds or the patient's employer. All such information would be available after a written request and the approval of the attending physician in the case.

5. **RELEASE OF MEDICAL RECORDS:** The undersigned authorize the release of information in the's medical records to his private physician and to any physician, hospital, or agency to which the patient is referred by **Healthline Medical Group**. The undersigned also authorize any private physician and any physician, hospital or agency to which the patient is referred to release to **Healthline Medical Group** information regarding treatment by or at said physician, hospital or agency.

6. **INSURANCE ASSIGNMENT:** The undersigned hereby authorize payment directly to **Healthline Medical Group** of any benefits payable to the patient including disability insurance and payment under Title XVIII of the Social Security Act which is applicable to the patient's account, but not to exceed the hospital's regular charges. The undersigned understand that the undersigned are financially responsible to **Healthline Medical Group** for charges not covered by the patient's hospitalization plan.

7. **RELEASE FOR FUTURE CONTACT:** The undersigned hereby authorize **Healthline Medical Group's** staff to contact the patient subsequent to the present visit for information relating to the patient's medical condition.

The undersigned certify that they have read the foregoing and are the patient, or duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Signature of patient

Witness

Date

Husband, Wife, Guardian or Nearest Relative, or Person
Assuming Responsibility for the Account.