Notice of Privacy Practices, Financial Responsibility, Consent for Treatment

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Suffix	DOB DD/MM/YYYY
				___/___/_____

Please complete the following information regarding how we may contact you regarding treatment, test results, or status of your account.

Can we contact you at your home phone?	☐ Yes	☐ No
Can we leave a voice mail on your home phone?	☐ Yes	☐ No
Can we contact you on your mobile phone?	☐ Yes	☐ No
Can we leave a voice mail on your mobile phone?	☐ Yes	☐ No
Can we send you medical information about your visit through our secure online patient portal?	☐ Yes	☐ No

PERMISSIONS

☐ Yes, I give permission to verbally discuss my medical condition(s), treatment, and information regarding my treatment with the following individual(s):

_____/_____
Name/Relationship

_____/_____
Name/Relationship

_____/_____
Name/Relationship

☐ No, I do not give permission to discuss my medical condition(s), treatment, and information regarding my treatment with anyone else.

ACKNOWLEDGEMENT

My signature on this form acknowledges that I have been made aware (and can request a copy) of Cayman Medical's **Privacy Notice.** I also acknowledge that I am aware that I may address questions regarding the contents of the document at the Center prior to my visit.

My signature on this form also acknowledges that I have read the Cayman Medical's **CONSENT FOR SERVICE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**, **PATIENT FINANCIAL RESPONSIBILITY AGREEMENT**, and **GENERAL CONSENT FOR CARE AND TREATMENT** below and agree to the outlined terms.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent that Cayman Medical's Team may use or disclose Protected Health Information (PHI) through verbal, written, analog or digital (ePHI) ways to carry out payment, diagnostics or treatment. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for thepurpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits and agree to pay any remaining balance once my Insurance Plan has processed my claim.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. You are responsible for informing your provider if a specific medical, imaging or laboratory facility is required by your insurance carrier for any medical, imaging or laboratory services ordered. Many insurance companies have additional stipulations that may affect your coverage.

You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.
I have read the above policy regarding my financial responsibility to Cayman Medical, for providing services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Cayman Medical, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier. If I do not have health insurance and will be responsible for services rendered here at Cayman Medical, I agree to pay Cayman Medical the full and entire amount of treatment given to me or to the above-named patient. I understand that for any balances over 90 days old, Cayman Medical reserves the right to refer the account to a collection agency where an additional collection fee may be added to the total balance due.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay the deposit for the office visit before services are rendered
- In addition, any remaining balance on your account will be collected at time of discharge

Workers Compensation Policy

- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer

GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This Consent Form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This Consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended: and (2) you consent to treatment in this Center or any other satellite office or Center under common ownership. This Consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, you are encouraged to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has been brought me to seek care at this Center. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ ____/____/_____

Patient or Guardian Signature Date DD/MM/YYYY