Patient Consent Form

Consent to Medical Services
I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood-borne infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency), if a physician orders such tests for diagnostic purposes.

Financial Agreement

- I acknowledge that as a courtesy, **Ogden Internal Medicine** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

Third Party Collection
I acknowledge that **Ogden Internal Medicine** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits
I hereby assign to **Ogden Internal Medicine** any insurance or other third-party benefits available for health care services provided to me. I understand **Ogden Internal Medicine** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Ogden Internal Medicine**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Payment Agreement
The patient/responsible party or legal guardian obligates themselves to the payment of charges incurred in accordance with the regular rates and terms of the practice at time of discharge. If the patient/responsible party fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the patient/responsible party shall pay a 29% collection fee and all court costs and attorney's fees.

Medicare Patient Certification
I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Ogden Internal Medicine** by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications
I agree that, in order for **Ogden Internal Medicine** , or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Ogden Internal Medicine** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Ogden Internal Medicine** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

I hereby certify and state that I have read and been given the opportunity to ask questions about this Patient Authorization, I fully understand this Patient Authorization and that I have signed this Patient Authorization knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any Laboratory procedure or other services and I have signed this document without inducement, other than the rendition of services by the healthcare facility and/or facility-based physicians.

X____
Patient/Parent/Guardian/Conservator **Relationship to Patient** **Date**

X____
Print Patient Name

X____
Witness Signature **Print Name** **Date**