PERMISSION FOR TREATMENT AND PAYMENT PROCEDURES, PRIVACY NOTICE, AND POLICIES

I acknowledge that payment for services and supplies normally are due in full at the time services are rendered. In consideration for the Provider (Jill Gibson, MD) not requiring me to pay all charges for care and services rendered during my visit at the time of delivery, I hereby assign to Provider any and all rights to receive insurance benefits otherwise payable to me for products or services provided by Provider, to the extent payable. I understand that my signature requests that payment by my insurance carrier be made directly to Provider. I authorize Provider to appeal denied insurance authorization and/or benefits on my behalf. I agree to cooperate with the requests of the Provider for assistance in efforts made by the Provider to assist me in filing and collecting claims for coverage. If my insurance carrier does not accept an assignment of benefits, I understand that all correspondence and payments to Provider may be sent directly to me. I agree that when and if any such payments are received, I will hold them in trust for Provider and promptly and immediately transmit them to the Provider for payment of my bill. I acknowledge that this assignment of benefits in no way absolves me from financial responsibility for ensuring that the Provider is promptly paid in full for all charges for care, services and supplies regardless of the availability or lack of insurance coverage for such charges. I am responsible for the deductible, co-insurance, and non-covered services as well as any other charges not promptly paid by my insurance carrier. I agree that I will be financially responsible for and promptly pay the Provider for any claim or portion of claim thereof, due to Provider for supplies and/or services not covered by my insurance policy as of the date that care, service or supply was rendered. If my insurance company denies coverage or within 45 days of billing by the Provider has failed to pay for all or any billed charge, I will promptly pay the provider for the full amount of any such charges. If my insurance coverage changes, I will promptly notify the Provider. I understand that Provider has a legal obligation to seek payment from me for co-insurance amounts owed and that this agreement supersedes and will prevail over any other agreement to the contrary. I further agree and understand that this office can only code and file a claim for my visit with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate, fraudulent, and will not be done. In the event I do not pay for these or any other services provided me when due, I agree to pay all costs of collection (there will be a $75 fee assessed for all accounts sent to collections, and all court costs). A fee is charged when appointments are not kept or are canceled with notice of less than one business day, or I am more than 15 minutes late. Checks returned from my bank will be charged the highest fee allowed by law and, if not promptly paid, prosecuted to the fullest extent of the law. Any modification, deletions, or changes to this form are void and will not be honored.

Initial: _____

I have received or have been allowed to view a copy (available from the receptionist and at www.jillgibsonmd.com) of Jill Gibson MD, LLC office privacy notice as required by HIPAA.

Initial: _____

I authorize Jill Gibson MD, LLC to leave a message on your answering machine or voice mail concerning normal lab results? I (the patient) understand that answering machines and cell phones are not secure lines.

Initial: _____

I authorize Jill Gibson MD, LLC to leave a message on your answering machine or voice mail for appointment reminders or to schedule an appointment and or email. I (the patient) understand that answering machines and cell phones are not secure lines.

Initial: _____

I authorize Jill Gibson MD, LLC to send appointment reminder texts to your cell phone? I (the patient) understand that cell phones are not secure lines and will be responsible for any applicable charges to receive texts.

Initial: _____

Consent for Treatment

I hereby authorize the practice, its agents, employees and physicians or other medical providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to be regarding my care and treatment. I understand that the practice is affiliated with a teaching hospital and other academic affiliates. I consent that fellows, residents, interns, medical and nursing students and other professional students to observe in or assist in my care and treatment under the supervision of my physician. This consent is valid for the course of my treatment or until revoked.

Initial: _____

Authorization to Release Information

I hereby authorize the physician/practice participating in my care to release either verbally or in writing, any medical information which may be needed to assist in my continued care plan or be needed to process claims for medical insurance benefits relative to my care. I understand that my treatment provider(s) will access my prior medical records to aid in treatment. I authorize the physician/practice to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from the physician/practice on behalf of myself and/or my dependents, and understanding that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is considered as valid as the original.

Initial: _____

I have read, reviewed, received, and acknowledge and agree to **the general office policies of Jill Gibson MD, LLC. (**available from the receptionist and at www.jillgibsonmd.com)

Initial: _____

I have read, reviewed, received, and acknowledge and agree to **the Laboratory and Diagnostic Policy of Jill Gibson MD, LLC. (**available from the receptionist and at www.jillgibsonmd.com)

Initial: _____

I have read, reviewed, received, and acknowledge and agree to **the financial and insurance policy of Jill Gibson MD, LLC. (**available from the receptionist and at www.jillgibsonmd.com)

Initial: _____

I authorize Jill Gibson MD, LLC discussion of my general medical condition and diagnosis (including treatment, payment, and health care options) with:

_____

I certify that I am the patient or the patient's duly authorized representative and that the information given by me to Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

Signature: _____ **Date:** _____

Printed Name _____ **Witness** _____

MINOR PATIENTS : (Parents Please Note) Even though parents of minors are responsible financially, minor patients have a right to complete confidentiality by our office and that is protected by Louisiana Law. We can not speak to any parent without consent from the patient.