Lubbock Gastroenterology

Patient Name: _____ Phone #_____ DOB: _____ MRN: _____

CONSENT TO TREATMENT

I consent to receive medical and health care services, including diagnostic procedures, examinations, x-rays, anesthesia, or medical or surgical treatment, provided under the instructions of the Lubbock Gastroenterology physician(s), employees, and other health care providers as they deem reasonable and necessary. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I authorize Lubbock Gastroenterology and advanced practice providers to e-prescribe my prescriptions and request my prescription medication history from other healthcare providers or third party pharmacy payors. I understand that this means Lubbock Gastroenterology and my physicians and advanced practice providers may send or receive my prescription electronically. My medical records and prescriptions will also be made available to other healthcare providers through Health Information Exchanges (HIEs). I may opt out of participating in HIEs by completing an opt-out form at registration or by calling 806-696-4440 to obtain a form by fax, mail or email.

I understand that this Consent to Treatment will be valid and remain in effect as long as I attend or receive services from Lubbock Gastroenterology, unless revoked by me in writing. Any revocation will not be effective until received by Lubbock Gastroenterology.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I acknowledge that I am legally responsible for all charges billed to me for the medical and health care services provided to me by Lubbock Gastroenterology. I assign all of my rights, title, and interest in all insurance benefits otherwise payable to me for medical or health care services to Lubbock Gastroenterology. I authorize direct payment to Lubbock Gastroenterology of any insurance benefits payable to me or on my behalf for medical or health care services furnished to me. I understand that I am responsible for knowing the terms of my insurance benefits and certify that the information given regarding my insurance is accurate and current to the best of my knowledge. I understand my insurance company may not approve or reimburse my medical services in full. I promise to pay Lubbock Gastroenterology all charges billed to me for the medical and health care services received that are not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/-Medicaid, my insurance company, or other third party payor. I understand that payment may be due at the time of service for any medical and health care services not covered by my insurance company. If my account is referred to an attorney or outside agency for collection, I agree to pay reasonable attorneys' fees and collection expenses.

I understand that I may be asked to pay a deposit prior to a visit and/or obtain a referral, if needed prior to a visit.

I understand that this Financial Responsibility/Assignment of Benefits will be valid and remain in effect as long as I attend or receive services from Lubbock Gastroenterology.

I certify that I have read and understand this information and that all of my questions have been answered to my satisfaction.

_____	_____	_____	_____
Patient/Authorized Legal Representative Signature	Relationship to Patient	Date	Time

_____	_____
Printed Name	Witness/Translator