SIGNATURE SECTION

To the best of my knowledge , the information on this registration form is complete and correct. I understand it is my responsibility to inform my doctor and his staff if there is a change in health, insurance and/or contact information.

Patient Signature ____ Date _____________

CONSENT TO TREATMENT

I voluntarily consent to medical care at Consolidated Medical Practices of Memphis for routine diagnostic examination and medical treatment including but not limited to, routine laboratory work (such as blood, urine, and other studies) including x-rays, heart tracing, and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistants, or their designees as necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at Consolidated Medical Practices of Memphis.

I promise, as a patient of Consolidated Medical Practices of Memphis, I will follow all office policy that pertains to the patients of the office. I understand if I am not compliant with following the physician's plan of care, I can be terminated from the practice. By signing this I agree to follow the plan of care to the best of my ability.

Patient Signature ____ Date _______________

PRIVACY ACT STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient Signature ____ Date ___________________

BENEFIT AUTHORIZATION

(a) I authorize Consolidated Medical Practices of Memphis to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
(b) I also request that payments of authorized benefits be made to me or on my behalf to Consolidated Medical Practices of Memphis for services rendered.
(c) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.
(d) I authorize the use of my signature on all insurance submissions.
(e) I understand I am responsible for payment of all medical expense incurred due to services rendered at the time of service.
(f) I agree to provide complete and accurate information about all of the insurance policies that I participate in and advise the doctor and staff of any changes.

PATIENT SIGNATURE ____ Date ______________________

RELEASE OF INFORMATION DESIGNATION

I authorize physicians and staff of Consolidated Medical Practices of Memphis to speak with the following people regarding insurance and billing concerns

NAME ______________________________ **Phone #** _________________________ **Relationship** __________

I authorize physicians and staff of Consolidated Medical Practices of Memphis to speak with the following people regarding health care, plan of treatment, medications and lab/test results.

NAME ______________________________ **Phone #** _________________________ **Relationship** __________

ACCOUNT COLLECTION AGREEMENT

In the even your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become part of the Total Amount due. In the event your account is placed with an attorney, you will be responsible for the reasonable attorney fees and court costs.

You agree, that in order for us to service your account or to collect any amounts you may owe we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone number, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

Patient Signature ____ Date _______________