CONSENT/AUTHORIZATION for TREATMENT

1) I consent to services, treatment and diagnostic procedures, including but not limited to medications and lab tests which may be ordered by my provider at Executive Medical Clinic of Lake Charles. This also includes services such as telemedicine.

2) I acknowledge full responsibility for the payment of such services and ages to pay my bills in full AT TIME OF SERVICE unless other arrangements are made. By signing this consent, I assign all rights, title and interest and authorize direct payment to the Executive Medical Clinic of Lake Charles of any insurance benefits or benefits under the Social Security Act for the services. Executive Medical Clinic of Lake Charles will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment. I authorize Executive Medical Clinic of Lake Charles to bill my insurance or third party payer and receive payment from them directly.

3) I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, Executive Medical Clinic of Lake Charles may disclose my records to any person, Social Security Administration, insurance or benefit payer, health care services or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges. Furthermore, Executive Medical Clinic of Lake Charles may disclose my records to other treating providers, health care provider, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

4) My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. This authorization shall remain valid for a period of one year unless I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Signed: ____Date:
(Patient, Parent or Guardian)

Relationship to Patient: __________________________Date: