The Columbia Medical Group
A Lexington Medical Center Physician Practice

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Lexington Medical Center

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **The Columbia Medical Group** who may attend me, their assistants, including those employed by **The Columbia Medical Group** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV. _____ (*initials*)

I authorize LMC Physician Practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose._____ (*initials*)

I consent and give permission to **The Columbia Medical Group** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows LMC Physician Practices to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to LMC Physician Practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to LMC Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to LMC Physician Practices and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. _____ (*initials*)

Print Patient Name:_____ DOB: _____

Patient Signature:_____ Date: _____

Responsible Party Signature (if different):_____ Date: _____