BEVERLY A. CARL, MD

Consent for Treatment and Payment Agreement

CONSENT FOR MEDICAL CARE

I, _______________________, consent to medical evaluation and treatment by the physicians and employees of Dr. Beverly Carl. I understand that my medical evaluation and treatment may include certain diagnostic tests. In addition, my physician may determine that certain invasive procedures are necessary. I understand that I may discuss my medical treatment with my physician and may withdraw my consent if I so desire.

Signed ____ Date ________________________

Relationship (parent/guardian_ ____

FINANCIAL ARANGEMENTS/RELEASE OF INFORMATION

1. I agree to the following terms with respect to payment for all services provided.

   a. I authorize Dr. Beverly Carl to bill my insurance carrier and request such payments be made directly to Dr. Carl. I certify that the information given by me with respect to insurance coverage or other payment sources is correct.

   b. I assign Dr. Beverly Carl all rights to insurance payments or other benefits to which I may be entitled for the services rendered.

   c. I authorize Dr. Beverly Carl to release any medical information about this treatment or service, if required, in order to obtain payment from my insurer or other payor as well as any such records or information as may be required by my insurer.

2. I understand that any amounts not paid or denied as not medically necessary by my insurance, including co-payments and deductibles, are my responsibility. I agree to pay the full charge for all services rendered by Dr. Beverly Carl at the time of service.

   *Upon your request, a Patient Account Representative will discuss charges you will encounter for services provided.

Guarantor Signature for Financial Arrangements ___________________________________

Date ____________________

MEDICARE LIFETIME ASSIGNMENT

I request that payment of authorized Medicare Benefits be made on my behalf to Dr. Beverly Carl for any service(s) furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

Signed ____ Date ________________________

HIPAA ACKNOWLEDGEMENT AND CONSENT

I have received the Notice of Privacy Practices for Dr. Beverly Carl. Dr. Carl is authorized to use and disclose health information about ______________________ (patient name) for treatment, payment, and healthcare operations purposes consistent with her Notice of Privacy Practices.

Signature of Patient or Representative ____ Date ________________________

Name of Representative ____________________________ Relationship to Patient ___________________________________
(or other authority)