SOUTH COUNTY ENDOCRINOLOGY & OBESITY MEDICINE
12900 Tesson Ferry Rd, Suite 101 St Louis, MO 63128
Phone: 314-843-4848 Fax: 1-866-510-2730

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANICAL RESPONSIBILITY

1. **CONSENT:**

I authorize my physician and her employees, to provide the medical care, tests, procedures, drugs, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency and other special services. In consenting to treatment, I have not relied on any statements as to results.
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.

2. **STORAGE AND RELEASE OF INFORMATION:**

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. Any governmental or other entity as required by law for purposes of reporting or for purposes of determining the eligibility in government sponsored benefit programs.
b. The supplier off any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
c. Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.
d. Another health care provider that prescribes medication electronically to provide continuity of care and quality of care issues regarding prescriptions.
e. I also authorize my physician to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.

3. **MEDICARE/TRICARE INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by the South County Multispecialty Practice. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.
I (or my representative) certify that I [or he/she] have read [or if the patient/Representative, is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

4. **GUARANTEE FOR PAYMENT:**

In accordance with the above terms and in consideration of the services provided to the above-named patient by South County Multispecialty Group, the undersigned agrees, whether he/she signs as patient OR guarantor, to pay South County Multispecialty Group for all services ordered by the physician or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by a insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred. . A photostat of the authorization shall be considered as effective and valid as the original.

5. ASSIGNMENT OF INSURANCE BENEFITS: In consideration of any and all medical services, care, drugs, supplies equipment and facilities furnished by South County Multispecialty group, I authorize direct payment to South County Multispecialty group of all t insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me. In addition, I hereby authorize payment to the Hospital of applicable insurance benefits for medical and/or surgical services rendered by physicians for whom the Hospital is authorized to bill, and collect.

HIPAA - Notice of Privacy Practices Acknowledgement

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that South County Multispecialty group and their staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern South County Multispecialty group operations and responsibilities.