TEMPLE HEALTH

Consent for Treatment and Authorization to Pay Benefits

Consent for Treatment:

I hereby generally consent to the rendering of care, which may include routine diagnostic and therapeutic procedures, as the attending physician and such associate assistants and other health care providers deem necessary.

I understand that:

A) It is customary, except in case of an emergency or extraordinary circumstances, that no surgical or invasive procedures are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional.

B) Each patient has the right to consent; or to refuse consent, to any procedure without his/her full knowledge and consent. I understand the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as a result of examination or treatment in this office.

Authorization to Pay Benefits:

Medicare Patients

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. 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 these benefits or the benefits payable for related service.

Commercial Insurance Patients

I authorize that any insurance benefits for services and/or medical care rendered by Temple Physicians, Inc., or its designees be released by the insurance carrier or others who are financially liable for services and/or medical care. I also authorize Temple Physicians, Inc. or its designee, to release to insurance carriers or others who are financially liable for services all medical records and other information needed to substantiate payment for related services.

Payment Guarantee

I, and the undersigned agree to assume full financial responsibility, and to personally guarantee payment of all charges hereafter incurred at Temple Physicians, Inc., and not paid for by insurance. This payment is expected within 30 days of notification of any balance not paid by the insurance carrier. I understand that if this bill is not paid within this time period, the account may be turned over to the designated collection agency.

I certify that I have read and fully understand the above.

_____ _____

Patient/Guarantor/ or Guardian Signature **Date**

_____ _____

Witness **Date**

TEMPLE HEALTH

CONSENTIMIENTO PARA TRATAMIENTO Y AUTORIZACIÓN DE PAGO DE HONORARIOS
Consent for Treatment and Authorization to Pay Benefits

CONSENTIMIENTO PARA TRATAMIENTO
Consent for Treatment

Yo consiento en recibir servícios de tratamiento médico los que pueden incluir procedimientos terapeuticos y diagnosticos rutinarios de acuerdo en el juicio del médico y/o sus asociados, o cualquier otro proveedor de servícios de salud.

Yo entiendo que:

A) Es acostumbrado, excepto en casos de emergencia o circunstanciones extraordinarias, que ning˙n procedimiento surgical o invasivo será llevado a cabo en ning˙n paciente a menos que, haya tenido opurtunidas de discutir con el médico o cualquier otro proveedor de servÌcios de salud.

B) Cada paciente tiene el derecho a consentir, o reprochar, recibir cualquier tratamiento sin su completo conocimiento y autorización. Ademas, la practica de la medicina y la sirugia no son ciencias exactas; que los diagnosticos y tratamientos podrian envolver cierto riesgos de daños o incluso muerte. Reconozco que no se he ha hecho garantia alguna como resultado de examenes o tratamientos llevados a cabo por esta agencia.

AUTORIZACIÓN PARA PAGOS DE BENEFICIOS
Authorization to Pay Benefits

PACIENTES DE MEDICARE
MEDICARE PATIENTS

Yo solicito que los beneficios bajo el programa de seguro medicare sea hecho a Temple Physicians, Inc. en todas factura por todo servício que me ha sido puestado por Temple Physicians, Inc. Autorizo a Temple Physicians, Inc. a suministrar al Health Care Financing Administration o otro contribuyente secund·rio y sus agentes cualquier información médica que sea necesária para determinar los beneficios pagables por servícios a fin.

PACIENTES DE SEGURO COMERCIAL
COMMERCIAL INSURANCE PATIENTS

Autorizo a que todo beneficios de seguro por concepto de servÌcios médicos puestados por Temple Physicians, Inc. sea pagados directamente a Temple Physicians, Inc. Autorizo a Temple Physicians, Inc. o sus designados a suministrar toda información necesaria para que pagen mi servicios médicos.

GARANTIA DE PAGOS
PAYMENT GUARANTEE

Yo y los abajo suscritos acordamos asumir completa responsabilidad financiera y garantiz amos pagos de todo cargo incurido de aquÌ en adelante con Temple Physicians, Inc, que no sea pagado por mi seguro de tercer partido. Se espera que todo cargos deben ser pagados en treinta dias de la notificación de balances que no son pagados por el seguro del tercer partidos. Entiendo que si todo cargo no sea pagado dentro de los limitos establecidas por este contrato, la cuenta ser· dado a una ajuencia de colección.

Certifico que he leido y entendido los terminos arriba descritos.

_____ _____

Paciente/Fiador/Allegado Signatura **Fecha**

_____ _____

Testigo **Fecha**