Breast Care Specialists AMC

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1. CARE CONSENT

I/we consent to service, treatment and diagnostic procedures as may be deemed necessary or advisable by Drs. Sockrider and Mook Broadwell and/or consultants selected by my physician. The consent to facility care includes permission for X-Ray examinations, laboratory procedures, I.V. treatments, injections, medications and services rendered to the patient under the general and special instruction of the doctors. The patient acknowledges responsibility in any or all of these procedures. The patient has the right to consent to surgery and procedures. Except in emergencies or unusual circumstances, Breast Care Specialists AMC does not allow its facilities to be used without this discussion and patient's consent. I voluntarily give my consent to care.

2. AUTHORIZATION FOR RELEASE OF INFORMATION

The employees and agents of Breast Care Specialists AMC and copy services and electronic claims processing services under contract with any third party billing agents or any of its staff physicians involved with patient care are given permission to release any and all information relating to the patient, including but not limited to the medical record of the patient care, to another health care provider if the patient was transferred to that facility and to any and all insurance companies or other third parties paying or obligated to pay, in whole or in part, the charges incurred by the patient; and they are also given permission to release the above described information to any agent or firm working for or with the above described insurance companies or other third party payers for the purpose of performing pre-certification, concurrent and/or retrospective review and/or other utilization review of any kind.

3. VALUABLES

I understand and acknowledge that Breast Care Specialists AMC assumes no responsibility for personal possessions including cash, jewelry, bridge work, eyeglasses or any other personal possessions. I have been advised that such valuables should not be left unattended and should be placed in the care of my family or custodian.

4. SAFETY CODE

Safety codes are issued and followed by the National Fire Protection Association. Guidelines are strict and safety inspections and drills are performed quarterly.

5. ASSIGNMENT TO PHYSICIANS

In consideration for services rendered or to be rendered to the above patient by this medical treatment facility for illness, injury or diagnostic services on the date(s) indicated, I hereby assign to said medical facility all benefits due to me covering medical expenses under the identified policy number, insofar as they are necessary to cover such expenses. I hereby assign to all physicians who treat me the benefits due me for these services covering medical and/or surgical expenses. I agree that should the amount be insufficient to cover the entire medical/surgical expense, I will be responsible to said physician(s) for the payment of the differences, and that is the nature of the disability such that it is not covered by the policy, I will be responsible to the physician(s) for payment of the entire bill.

6. MEDICARE CONSENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (SSA) is correct. I authorize Breast Care Specialists AMC to provide SSA or its intermediaries with access to my medical record for the purpose of processing the Medicare claim for this or a related Medicare claim. I further request that Breast Care Specialists AMC provide such copies thereof as may be requested. Copies may be made by Breast Care Specialists AMC or its agents, or contractors providing copy service and electronic claims processing services and said third party billing agents for Breast Care Specialists AMC and staff physicians involved with patient care. This form has been fully explained to me. My signature reflects my understanding of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirely to a dependent for whom I am responsible for and/or who is unable to consent on their behalf for the reason(s) indicated below. I request payment of authorized Medicare and/or Medigap benefits be made to this provider for services rendered.

Patient Signature X______________________________ Witness ___________________________

Signature of person responsible for bill ____

Relationship _____________________________________ Date ___________________________

Patient unable to consent because ____