VERIFICATION OF INFORMED CONSENT FOR GENERAL CARE AND TREATMENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

Informed Consent for General Care and Treatment:

I, ________________________________, voluntarily consent to and authorize Terry Reilly, its staff, physicians, and other practitioners to administer, provide, and perform, such general medical care, tests, routine procedures, and other services that are deemed necessary, advisable, or beneficial by the providers to effectively diagnose and treat me. This includes all routine diagnostic tests and procedures, including x-rays, the administration or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of such treatment and care for my condition.

Excluding a medical emergency or extraordinary circumstances, I understand that no substantial procedure will be performed without providing me with an opportunity to give or refuse informed consent for that specific procedure. In giving my general consent for care and treatment, I understand that I retain the right to refuse any particular examination, proposed care, testing, surgery, procedure, treatment, therapy or medication and that I have the right to revoke this general consent for care and treatment at any time. Unless revoked earlier, I understand that this general consent for care and treatment will be valid for a period of one (1) year from the date of my signature below.

I voluntarily request Terry Reilly and its medical, nursing, and other professional staff or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care and treatment at Terry Reilly.

Financial Responsibility/Release of Information:

Financial Responsibility- I understand that it is my responsibility to provide Terry Reilly with accurate and complete information concerning my primary and secondary insurance benefits, including referral documents from other providers. Current identification and insurance benefit cards will be presented at each office visit. As a courtesy, Terry Reilly will file my claim for me.

For services outside of Terry Reilly, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers I understand that it is my responsibility to know which facility I am required to use according to my specific benefits. The charges for these services will not be applicable for Terry Reilly's sliding fee program and are 100% my responsibility. If I am uncertain, I recognize I can speak with member services or one of the billing staff before scheduling services outside of Terry Reilly.

Insurance-Terry Reilly is a participating provider in many insurance plans and will file my claim as a courtesy to me. In order to properly bill my insurance, it is my responsibility to disclose all insurance information including primary and secondary plans, as well as any change of insurance information. Failure to provide complete and accurate insurance information will result in my responsibility for the entire bill. If any of Terry Reilly's providers are not listed in my plans network, I may be responsible for partial or full payment. If Terry Reilly is out of network and my insurance company pays me directly, I am responsible for payment and agree to forward the payment to Terry Reilly's Patient Financial Services immediately.

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Co-pays-I understand that payment is expected at the time of my visit. Terry Reilly accepts cash, check and credit card as well as Care Credit for Dental. Payment will include any unmet deductible, co-insurance, co-payment or non-covered charges from my insurance company. If I do not have insurance and qualify for a sliding fee, my copay for services will be expected at time of my visit. Payments made the date of the visit are treated as a deposit to my account and will be applied after my visit. If charges for my services exceed my payment I will be billed for the remainder of the balance. Any credits on my account will be applied to outstanding due balances before being refunded to me.

All of my payments made on outstanding balances will be applied to the oldest date of services across all facilities.

Payment Plans-I am aware that if I fall under hardship and need to make payment arrangements I may do so either by calling Patient Financial Services, in the clinic or online in my portal.

Pre-payment – I understand that prepayment for services is allowed and should be communicated to Terry Reilly when the payment is made in order to ensure it is applied appropriately. Deposits will be held for 3 months at which time any remaining credits on my account will be applied to any outstanding balances with Terry Reilly and the remainder refunded to me.

Nonpayment- I agree to pay any balance remaining on my account. I understand that if I fail to pay the balance on my account, this may result in my balance being turned over to an outside collection service.

Estimates for charges- I understand that any estimate provided to me for charges is just an estimate. Exact costs cannot be determined prior to services and any remaining balance above the estimate given to me will be billed for payment.

Assignment of Benefits- I authorize direct payment of medical benefits to Terry Reilly Health Services. This authorization will remain in effect until cancelled by me in writing.

Release of information- I authorize the release of any medical information necessary in order to obtain payment from my insurance company, Medicare, other physicians or providers, and any other third-party payers and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collections charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of the services provided to me. I understand that if I apply for special programs or other assistance, my information may be shared with those programs and their auditors.

MVA/Work Comp- If my visit is due to a work-related injury or auto accident, I am responsible to provide Terry Reilly with the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment. I understand that if my claims are denied or I fail to provide the necessary billing information I will be financially responsible for my bill. Terry Reilly does not bill third party billing for auto accidents. It is my responsibility to open a claim with my auto insurance and provide the necessary billing information for these visits.

Returned Checks-The charge for a returned check is $25 payable by cash, credit or money order. Should my check be returned, I understand that this charge will be applied to my account in addition to the returned insufficient fund amount.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS VERIFICATION OF **INFORMED CONSENT FOR GENERAL CARE AND TREATMENT** AND STATEMENT OF **FINANCIAL RESPONSIBILITY**. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND ANY QUESTIONS THAT I HAD, HAVE BEEN ANSWERED BY STAFF TO MY SATISFACTION.

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Signature of Patient Printed Name of Patient Date

□ Patient is unable to sign because ___________________________________. For this reason, I hereby verify that I have given my consent for general care and treatment on behalf of the above-named patient.

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Signature of Personal Representative Printed Name of PR Date