BAPTIST MEDICAL CLINIC
CONSENT FOR TREATMENT

Authorization for treatment, release of medical information, and assignment of insurance benefits.

AUTHORIZED TO RELEASE: I hereby authorize the Baptist Medical Clinic or my attending physician, to release or disclose to insurance companies and/or outpatient benefit programs information from my medical record pertaining to my treatment as needed to process insurance claims.

AUTHORIZED TO PAY INSURANCE BENEFITS: I hereby assign payment directly to the Baptist Medical Clinic benefits wherein specified and otherwise payable to me but not to exceed Baptist Medical Clinic regular charges for medical treatment. I understand I am financially responsible for charges not covered by this authorization.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER/PHYSICIAN: I certify that the information given by me in applying for payment under title XVII of the Social Security Administration or its intermediaries or carriers is the correct information needed for Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, and authorize such physician or organization to submit claims to Medicare for payment.

MEDICAID PATIENT CERTIFICATION: I certify that the information given by me in applying for payment as a recipient of the Medicaid Title XIX Program is correct and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the Mississippi Medicaid Commission any requested information concerning medical, insurance, financial records relating to my outpatient visits or hospital treatment. I hereby certify all insurance benefits shall be assigned to the Baptist Medical Clinic or to my attending physician for services rendered.

CONSENT FOR TREATMENT: The undersigned authorizes the physician assigned to furnish medical and surgical treatment by those means he/she considers necessary and proper in the treatment of the patients identified below while a patient of Baptist Medical Clinic. This treatment may require diagnostic procedures including but not limited to laboratory tests, blood drawing for those tests, x-rays and electrocardiogram.

FINANCIAL AGREEMENT: For services rendered to the patient named below, I the undersigned, agree to pay all professional, outpatient, hospital visit charges not covered by insurance and/or no show appointment fee. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

VALUABLES: The undersigned hereby releases the Baptist Medical Clinic and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

TERM: The term of this Consent for Treatment shall be for a period of one year from the date of this signature below, unless otherwise revoked.

Printed Patient Name ___________________________ Signature Patient/Guardian if minor ___________________________ Date ___________________________

Printed Patient Name ___________________________ Signature Patient/Guardian if minor ___________________________ Date ___________________________

Printed Patient Name ___________________________ Signature Patient/Guardian if minor ___________________________ Date ___________________________
### PATIENT INFORMATION FORM

<table>
<thead>
<tr>
<th>Patient Name</th>
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<tbody>
<tr>
<td>Last</td>
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<tr>
<td>Sex:</td>
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<td>Social Security #:</td>
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<td>Address</td>
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<td>City</td>
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<td>Home Phone:</td>
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<td>Work Phone:</td>
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<td>Ethnicity:</td>
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<td>Patient (Responsible Party) Signature:</td>
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### INSURANCE INFORMATION

Primary Insurance – Insurance Co. ________________________________ Policy #: ____________________________
Policy Holder: ____________________________ Birth Date: _____________ SSN: ____________________________
Address: (If different from patient) __________________________________________________________
City, State, Zip: ____________________________

Secondary Insurance – Insurance Co. ________________________________ Policy #: ____________________________
Policy Holder: ____________________________ Birth Date: _____________ SSN: ____________________________
Address: (If different from patient) __________________________________________________________
City, State, Zip: ____________________________

### PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information for you. You have the right to review our Notice of Privacy Practices before signing this acknowledgment. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting a copy in writing from the Privacy Office, Clinic Resource Management, Mississippi Baptist Medical Center, 1225 North State Street, Jackson, Mississippi, 39202 or at our website, [www.mbhs.org](http://www.mbhs.org).

By signing this form, you acknowledge that you have been provided a copy of and reviewed our Notice of Privacy Practices.

__________________________________________  ________________
Patient Signature | Date

__________________________________________  ________________
Witness Signature (Office Staff Only) | Date

Baptist Heart
501 Marshall Street, Ste 104
Jackson, MS 39202