Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee.

I understand that this Consent to Treat will be valid for each visit I make to the Midtown Oral & Maxillofacial Surgery until revoked by me in writing.

I acknowledge and consent to see a physician or other practitioner via telemedicine. I understand that my eligibility to receive a visit via telemedicine is based on the physician's medical judgment that it is appropriate, and the quality of care will not be diminished by the use of telemedicine. If telemedicine is appropriate for my encounter, I will communicate with the physician or other provider through advanced communication technology using live video and audio feed. I understand that my healthcare provider or I may terminate the telemedicine visit at any time, including if the provider or I feel that an in-person visit is necessary. I will have the telemedicine equipment, personnel, potential risks, and alternatives to telemedicine explained to me prior to a telemedicine visit. I understand that any complaint may be filed with the Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018.

2. Consent to Release Information

I acknowledge that Midtown Oral & Maxillofacial Surgery may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Midtown Oral & Maxillofacial Surgery's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Midtown Oral & Maxillofacial Surgery.

I acknowledge and consent to allow Midtown Oral & Maxillofacial Surgery to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Midtown Oral & Maxillofacial Surgery "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits

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I assign and transfer to Midtown Oral & Maxillofacial Surgery all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance.

4. Patient Financial Responsibility

I understand that as a recipient of oral surgery I am responsible for all charges regardless of my circumstances of reimbursement. Payment, including but not limited to co-pay, deductible, balances and non-covered services by insurance is due at the time of delivery of service. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate the doctor for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for services provided, notwithstanding any contract I may have with any third-party payer (for example, insurance company, employer, etc).

I understand that patient estimates and balances are due immediately and not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances. Should I fail to pay unpaid charges for more than 90 days my account will be referred to a collection agency.

I understand that I may be required to pay a $25 no show / cancellation fee, if I do not show up to an appointment or if I fail to cancel my appointment without a 24 hour notice.

Payment may be made with cash, check, or credit card (discover, visa, master card and American express). There will be a service charge of $35 for a returned check.

I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Midtown Oral & Maxillofacial Surgery staff are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorney's fees and collection expenses. In compliance with these terms, I agree to the following:

1. I will provide this office with complete and accurate billing information, including, but not limited to, a current insurance card and authorization numbers. I am responsible for all visits and procedures not properly authorized.
2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit unless otherwise arranged prior to the visit.

Minor Patients of Divorced Parents – By signing below I understand that if the patient comes from a divorced family, the parent that brings the child to the appointment and consents to the patient's treatment for the date of service is financially responsible.

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Out-of-Network/Self Pay

As the parent or guardian of the above-mentioned patient, I understand that my signature is my consent to treat as a Self-Pay patient account. Furthermore, I understand that, when applicable my insurance requires a referral/prior authorization for treatment to be considered (in the event of an HMO/DHMO plan whether in or out of network). Should I decide to take action and pursue reimbursement from my insurance and the claim denies for any reason, I understand that I will not be reimbursed for any funds paid to H. Paul Casmedes, DDS, MD, Dr. Ann H. Kristovich, DDS or Midtown Oral & Maxillofacial Surgery.

5. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Midtown Oral & Maxillofacial Surgery on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

6. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Midtown Oral & Maxillofacial Surgery or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

7. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that Midtown Oral & Maxillofacial Surgery will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

8. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

9. Notice of Privacy Practice

I acknowledge receipt of the “Notice of Privacy Practices” from Midtown Oral & Maxillofacial Surgery.

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_____	_____
Patient Printed Name	Patient Date of Birth
_____	_____
Patient/Responsible Party Signature	Date
_____	_____
Witness	Date