Patient Name: _____ DOB: _____

Consent/Authorization/Financial Obligation & Billing

Provider: We must emphasize that as medical care providers our relationship is with you, not your insurance company. Your insurance coverage is a contract between you, your employer, and the insurance company. We are not a party to your contract. (This does not pertain to carriers with whom we have HMP/PPO contracts.)

Consent to Treatment: I hereby grant SPO the authority to treat and examine me/my dependent and order the examination, test, treatment and other clinical services necessary for my care and treatment.

Insurance Authorization: I hereby authorize SPO to furnish my insurance carrier with information concerning my illness and treatment. I also authorize electronic transmission of my insurance claim to the carrier.

Medicare Assignment: I hereby request that payment of authorized Medicare Benefits be made to SPO for services provided.

Consent to Release Medical Records: I hereby authorize SPO permission to release medical records or patient information to any and all referring physicians, hospitals, auxiliary services referred by this practice, or firms that have been your representative.

Consent to Electronically Transmit (FAX): I hereby authorize SPO permission to electronically transmit (FAX) copies of medical records or patient's information to any and all referring physicians, hospitals and auxiliary services referred by this practice. It is my understanding that there are instances when electronically transmitted information may go somewhere other than the number dialed due to switching malfunctions at the phone company and SPO will not be held responsible.

Reasonable and Customary: I understand that SPO employees are specialists and that fees charged may be in excess of what my insurance carrier considers reasonable and customary. I understand that if my insurance company fails to pay, SPO will not be held responsible.

Payment of Office Visit/Insurance Guidelines: SPO holds numerous contracts with multiple insurance companies. Each year, on our contract date, we are required to evaluate these contracts, determine if we are willing to continue our participation with these insurance programs and continue to offer services to their participants. Some out of area insurance plans are location specific and will be verified prior to the appointment. Unless you or your health coverage carrier made other arrangements in advance, full payment is due at the time of service. For your convenience we accept: Cash, Check, American Express, Discover, Master Card, and Visa. A $25.00 service fee will be charged on all returned checks.

Assignment of Benefits: We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits (or **in-network benefits**). We will bill those plans for which we have an agreement and will only **require you to pay the authorized co-payment and applicable deductible amount at the time of your appointment**. As a courtesy, we will file your insurance claim for you if you assign benefits to the doctor; in other words you agree to have your insurance company pay the Doctor directly. If your insurance company does not pay the practice within a reasonable length of time, we will have to look to you for payment. I hereby assign all past, current and future medical benefits, if any, otherwise payable to me for services rendered directly by SPO. I authorize SPO to sign and deposit monies received on behalf of my medical care.

Billing for Minor: For all services rendered to minor patients, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

I understand that I can revoke at anytime except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Additionally, I acknowledge that I fully comprehend the consents and authorizations and that any questions I had were discussed with my physician and/or the staff.

_____ _____

Signature of Representative Date

_____ _____

Patient Representative (Print) Relationship to Patient

Dallas Location
7777 Forest Lane, Suite C135
Dallas, TX 75230

McKinney Location
5236 W. University Drive, Suite 2900
McKinney, TX 75071

(972) 347-4783 Office
(972) 347-4916 Fax