Disclosures and Consents

Patients or legal guardians for minor child MUST sign and date all paragraphs below before medical care can be rendered.

PATIENT INFORMATION	
Legal Name: (First) (Middle) (Last)	Date of Birth:

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Apex MD, or the providers individually, for services rendered to my dependents or to me by the physician or the clinician under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. **I understand and agree that I will be responsible for any co-payments, co-insurance, deductibles or balances due that are my responsibility for payment either at the time of service or after being notified that Apex MD is unable to collect from my insurance carrier for whatever reason.**

FINANCIAL RESPONSIBILITY:
I certify that I have received, read and understood Apex MD Patient Financial disclosure. I also understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorney for collections, that I undersigned shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the physician care of Apex MD. I am responsible for the entire charge of any service that I have consented to receive.

For Self-Pay patients, I also understand that I am responsible for all services rendered to my dependents or myself at the time of service.

MEDICARE INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my medical records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Apex MD, LLC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of Apex MD Notice of Privacy Practices and authorize the release. I hereby authorize Apex MD, LLC or the physician individually to release any of mine or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill for labs, x-ray, or other diagnostic services from another facility for which I am financially responsible for any co-payment, co-insurance, deductible or balance due for these services if they are not reimbursed by my insurance for whatever reason. I am responsible for any fees for labs that are not covered for any reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing and treatment for me or my dependents as directed by my physician/physician-extender or his or her designee at Apex MD.LLC. I understand the services may include lab tests, screening tests, diagnostic tests, and routine exams. I understand that no promises have been made to me about the results of any treatment or services.

PATIENT SIGNATURE: ______________________________ **DATE:** ______________
(or Legal Guardian, for minor patient)

PRINT NAME: ______________________________

GUARANTOR SIGNATURE: ______________________________ **DATE:** ______________
(If different from patient)

GUARANTOR NAME: ______________________________