



BON SECOURS MEDICAL GROUP

Name: _____

Date of Birth: _____

Social Security: _____

Dear Patient:

Welcome to our practice. Our goal is to provide the highest level of care for your problems. We will make every effort to meet your needs.

The policies listed below are meant to help familiarize you with our practice. Please do not hesitate to ask questions if any of these are unclear.

TREATMENT PERMISSION

You understand and consent to the following:

- That the physician taking care of you, the clinical staff and technical employees may give any treatment or perform any procedures as advised for your care and treatment.
- That you have the opportunity to discuss other plans for treatment with your physician to your satisfaction.
- That, if a health care worker has come in contact with your blood or body fluids in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, you consent to the testing of you blood and/or body fluids for these infections and to report your test results to the health care worker who has been exposed.

PAYMENT ARRANGEMENTS

- By signing this paper, you allow all payments to the medical practice of any insurance benefits otherwise payable to you for services provided under any insurance policy (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan.)
- By signing this paper, you allow release of information to insurance companies or other third party payors or their agents which may be necessary to determine coverage or which may be required for review, quality and management.
- You agree to pay, at the time of service, any required co-payments, co-insurance and deductibles as well as charges for services not covered by insurance.
- Unpaid balances will be billed to your permanent address.
- You are responsible for paying the bill in full unless other arrangements have been approved in advance.
- Past due accounts will be turned over to a collection agency and you will be responsible for collection charges as well as all associated legal fees in addition to the amount owed.
- By signing this paper, you allow any photocopies of this document to be as binding as the original.

*I have read, understand and agree to the Treatment and Payment Policies described above.
I understand and agree that these policies will be valid for one year from date signed.*

Patient or Guarantor Signature	Printed Name	Relationship to Patient	Date
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PRIVACY AND DISCLOSURE

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information.

By signing below, you are acknowledging that you have received our NPP.

Patient or Guarantor Signature	Printed Name	Relationship to Patient	Date
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Patient refuses to sign Privacy and Disclosure portion of form.

Reason: _____