TREATMENT AND PAYMENT ACKNOWLEDGMENT/CONSENT

Children's Hospital of The King's Daughters Health System

CMG of North Carolina, Inc.

Consent For Treatment

I hereby consent to medical and/or diagnostic treatment by CMG of North Carolina, Inc., and hereby authorize their physicians (and whomever he/she may designate as his/her assistant) and employees to treat myself or minor(s) in my legal custody, including stepchildren, in ways they determine to be therapeutically necessary. I understand that this treatment may include tests (lab/diagnostics), examinations, administration of medications, and medical or surgical procedures. I understand that during treatment, the possibility exists for health care workers to become directly exposed to the individual's blood or body fluids. The law authorizes health care providers to test patients for HIV antibodies, deemed consent, when the health care provider is exposed to the body fluids of a patient. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions. I consent to the release of prescription history from any drug pharmacy or drug monitoring agency to my physician or healthcare provider. I further consent to taking of photographs for treatment and/or payment purposes.

Obligation of Payment

I irrevocably direct and assign payment from my insurance company, Medicaid, Medicare, Tricare, or other provider of health care benefits to CMG of North Carolina, Inc. I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to CMG of North Carolina, Inc. for any charges not covered by my insurance including co-payments, deductibles, and fees for non-covered services. Some insurance plans require the laboratory department performing tests to bill for such diagnostic tests. In these instances, I understand that I will receive a separate statement and bill from the laboratory department performing the test. Upon default on any payment due to CMG of North Carolina, Inc., I agree to pay an interest rate of 8% which will be added to my balance and will continue to accrue annually for unpaid balances.

Balances Due and Billing Questions

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the office. I have been informed that a fee of $25.00 will be applied to my account for any returned checks. The RETURNED CHECK FEE is only payable in cash or by money order. Please direct all billing inquiries to Billing Representative at the practice where you received your care.

Acknowledgments/Certifications

I, the Parent/Legal Guardian/Patient acknowledge that;

- I was provided the "Patient/Family Rights & Responsibilities" and given an opportunity to ask questions about the information provided.
- I was provided the "Notice of Privacy Practices" and given an opportunity to ask questions about the information provided.
- I have read and agree to the terms of the "Patient Financial Policy". I certify that I understand the contents of this form.
- I certify that this form has been fully explained to me and I understand the contents of this form and that I am the patient or the patient's parent/legal guardian and have the authority to request this treatment. Furthermore, I permit a copy of this document to be used in place of the original. I certify that all statements are true and correct and I understand that false statements or documents or concealment of a material fact may be prosecuted under federal or state laws.

Thank you for selecting CMG of North Carolina, Inc. as your Health Care Provider

PATIENT(S) NAME (please print)	**DATE OF BIRTH**

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ RELATIONSHIP TO PATIENT/LEGAL AUTHORITY _____ DATE _____

Witness:_____ Date:_____

For office use only:

2nd Witness: (Verbal Consent Only)	Date	Name of Person Accompanying Patient

(Revised 12/12)