

SUNSET MEDICAL PRACTICE TERMS AND CONDITIONS
This Form Pertains to ALL Providers at Sunset Medical Practice Group, P.C.

CONSENT FOR RELEASE OF INFORMATION:

I understand and consent that health information received or created in the course of the delivery of health care at Sunset Medical Practice will be used or released for treatment, payment and health care operations as described in the Sunset Medical Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available upon request. I understand that Sunset Medical Practice Group will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information. I understand and agree that Sunset Medical Practice Group may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insure companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with arranged and be reimbursed to quality, cost-effective health care.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised notice of Privacy Practices. I also understand that a copy or summary of the most current version of Sunset Medical Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy practices, and I understand that Sunset Medical Practice is not required by law to agree to such requests.

STATEMENT OF FINANCIAL RESPONSIBILITY:

I agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. I hereby authorize my insurance benefits to be paid directly to the physicians and know that I am financially responsible for non-covered services. Some services that may NOT be covered by insurance include, but are NOT LIMITED to: Preventive care (Physical Examinations, Pap Smears, Well Child Checks), Injections, Excisions, Lesion Removals, Biopsies, and some Nurse Visits. I also understand that it is my responsibility to make sure that a service or procedure is covered by my insurance prior to that service or procedure being performed. I acknowledge that I am financially responsible for all charges, whether or not they are covered by insurance.

We use an automated reminder system to leave messages on your home phone regarding appointment information or to notify you that your test results are ready. These messages do not contain any specific health-related information. May we call you at your primary contact number with these messages? Y N (please circle one)

We are now offering electronic statements! If you would like to receive your billing statements as a secure email message, please fill in your email address below. If you DO NOT want to receive electronic statements, please leave blank.

EMAIL ADDRESS: _____

BY SIGNING BELOW, I AGREE THAT I HAVE REVIEWED AND UNDERSTAND SUNSET MEDICAL PRACTICE'S TERMS AND CONDITIONS.

PATIENT NAME (PRINTED): _____ **D.O.B.:** _____

SIGNED: _____ **DATE:** _____