

Centura Health Physician Group



1 CONSENT FOR HEALTH CARE SERVICES. I authorize physicians(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Centura Health practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary in person or telehealth. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Centura Health practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice. I further acknowledge Centura Health facilities and providers do not provide medical aid in dying medication or related services. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document. I understand that failure to comply with scheduled appointment times will put me at risk for discontinuation of medical care.

2 NON-CENTURA PRACTITIONERS. I understand that I may receive services from professionals who provide care to me who are not employees or agents of a Centura Health practice. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from the Centura Health practice. I understand that, in some cases, these non-Centura professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

3 MEDICARE and/or MEDICAID CERTIFICATION. I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4 FINANCIAL AGREEMENT. I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I understand this Agreement is a contract and that it obligates me to pay all charges for my treatment not paid by my insurer or any other payor source. I understand the practice has pre-determined the charges for certain procedures, supplies, and treatments, that these charges are listed in the Centura Health Physician Group fee schedule and that these prices are incorporated by reference into this Contract. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I agree to pay these current pre-determined rates for each supply and service I receive as part of my treatment. I acknowledge this Contract means I personally have full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payer. I acknowledge that estimated patient responsibility is due at the time of service and that any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 180 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt or any action on this Contract. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice.

5 COMMUNICATIONS CONSENT. By providing my cell or other phone number(s), I expressly consent to receive communications from the practice, its agents or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing,

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assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services. I consent to be contacted by regular mail, or by e-mail regarding any matter related to my account by the practice or any entity to which the practice assigns my account, including any collection agency. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account. I hereby acknowledge and agree that the practice has not made any implied representations about the charges I am personally obligated to pay.

6 PREAUTHORIZATION REQUIREMENTS. I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

7 ASSIGNMENT FOR DIRECT PAYMENT. I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

8 ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgment in no way affects the care I shall receive.

Acknowledge (Initials)

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Practice Representative Comments:

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

Signature of Patient or Legally Responsible Person

Patient/Responsible PartySignature

Self

Relationship to Patient