



Patient: _____ **Date of Birth:** _____

Patient Account Number: _____

AUTHORIZATION FOR TREATMENT

I, whether signed as the patient, the personal representative of the patient, or the patient’s legal guardian, hereby consent to and grant permission for the examination, testing, and treatment of patient by CaroMont Specialty Group (CSG).

RELEASE OF INFORMATION

I, whether signed as the patient, the personal representative of the patient, or the patient’s legal guardian, hereby authorize CSG to disclose by voice, fax, electronic or written methods, all or any part of patient’s medical information as necessary for treatment and billing purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I, whether signed as the patient, the personal representative of the patient, or the patient’s legal guardian, hereby assign to CSG, all insurance benefits to which patient may be entitled by virtue of insurance or public funding for services provided by CSG on behalf of patient. In addition, I authorize CSG to file claims for all services rendered by CSG on behalf of patient.

FINANCIAL POLICY

I have been provided a copy of CSG’s financial policy dated 7-1-2005 and understand and agree to its terms.

I, AS THE PATIENT, PERSONAL REPRESENTATIVE, OR LEGAL GUARDIAN OF THE PATIENT, HAVE READ, UNDERSTAND, AND AGREE TO ALL OF ABOVE TERMS.

Signed: _____ **Date:** _____

(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient)

THIS FORM CONTINUES ON THE REVERSE SIDE

ACKNOWLEDGEMENT OF RECEIPT – NOTICE OF PRIVACY PRACTICE

Our “Notice of Privacy Practices” document provides detailed information about the use and disclosure of my protected health information. I have the right to review the “Notice of Privacy Practices” document prior to signing this consent form. CaroMont Health encourages you to read our Notice of Privacy Practice in full.

Our “Notice of Privacy Practices” document is subject to change. You can obtain a copy of the current notice by accessing our website at www.caromont.org or by contacting our organization and requesting that a revised copy be sent to you in the mail or given to you in person.

I, AS THE PATIENT OR THE PATIENT’S PERSONAL REPRESENTATIVE, HAVE RECEIVED A COPY OF CAROMONT HEALTH’S “NOTICE OF PRIVACY PRACTICES” DOCUMENT. If this acknowledgement of receipt is not obtained (i.e. emergency treatment situation), CaroMont’s representative (witness) MUST document his/her good faith efforts to obtain the acknowledgement and the reason the acknowledgement was not obtained.

Signed: _____ **Date:** _____
(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient)

GOOD FAITH EFFORT AND REASON ACKNOWLEDGEMENT WAS NOT OBTAINED (DOCUMENTED BY CMG):

___ Patient refused to sign ___ Patient unable to sign ___ Other: _____

This form applies for services provided by all affiliates of CaroMont Health (CH) as listed below: Gaston Health Care, Incorporated, d/b/a CH; Gaston Memorial Hospital, Incorporated (GMH) and GMH d/b/a CaroMont Psychiatric Center; Gaston Health Services, Inc. and Gaston Services d/b/a CaroMont Health Services and d/b/a Courtland Terrace and d/b/a The Diagnostic Center and d/b/a CaroMont Specialty Surgery and d/b/a CaroMont Imaging Services; GMH Home Health Care/Med, Inc. d/b/a GMH Home Health Care, Inc.; CaroMont Medical Group, Inc. (CMG) and CMG d/b/a CaroMont Family Medicine and d/b/a CaroMont Pediatric Partners and d/b/a CaroMont Internal Medicine and d/b/a ID Associates and d/b/a Infusion Solutions and d/b/a Infectious Disease Associates and d/b/a Rehabilitative Medicine Associates and d/b/a CaroMont Psychiatric Associates and d/b/a CaroMont Urgent Care and d/b/a CaroMont Occupational Medicine and d/b/a Endocrinology Associates and d/b/a CaroMont Inpatient Physicians and d/b/a Gaston Perinatal Center; CaroMont Specialty Clinic, Inc. (CSG) and CSG d/b/a Carolina Heart Specialists and d/b/a CaroMont Thoracic Surgery.

PERSONAL REPRESENTATIVE AUTHORIZATION

*A personal representative is anyone that you would like for CaroMont Medical Group to release your patient information to, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. **If there are no names listed below we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or patient guardian.***

- I do not wish to select a personal representative.
- I authorize the following individual(s) to serve as my/patient’s Personal Representative with full authority to access or authorize review, release and/or copying of my/patient’s medical records:
 - 1) _____ 2) _____
 - 3) _____ 4) _____

I may revoke this request in writing, at any time except to the extent that action based on this authorization has already taken place.

Signed: _____ **Date:** _____
(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient)

If forms have been completed by someone other than the patient, please **print** name here: _____ Date: _____