Northside Hospital l Windermere Medical Group l Windermere Medical Clinic l Canton Primary Care

Patient Name:_____ DOB:___ __/_____/_____

FINANCIAL ACKNOWLEDGEMENT

ASSIGNMENT OF BENEFITS: Unless I have specified otherwise, verbally or in writing, in consideration of the services provided at Windermere Medical Clinic or Canton Primary Care or Northside Hospital, I hereby assign and transfer to the Hospital and other medical providers all hospital and medical provider benefits payable under my insurance policies or benefit plans. I hereby assign and transfer all related rights and remedies due under the insurance policies or benefit plans that I have identified or will identify in connection with all services rendered, including but not limited to all rights and remedies pursuant to applicable state, federal and ERISA regulation. I hereby assign and transfer all rights to the Hospital and other medical providers applicable under ERISA, federal or state regulation to pursue any benefit denial, limitation of coverage or request for an administrative review of fiduciary duties involving administration of benefits by the U. S. Dept of Labor, the Department of Community Health or the Department of Insurance. I authorize and direct the insurance company to pay all such benefits to the Hospital and appropriate medical providers. I understand that assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the Hospital. I certify that the information I have provided with respect to my coverage is true and accurate. I also understand that Northside Hospital may have to submit my health information for this or a related claim, including confidential information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. This assignment will remain in effect until revoked by me in writing.

ABOUT YOUR BILLING: IN ORDER TO ACCOMMODATE THE NEEDS OF OUR PATIENTS, WE HAVE ENROLLED IN NUMEROUS INSURANCE PROGRAMS.WHILE WE ARE PLEASED TO BE ABLE TO PROVIDE THIS SERVICE TO YOU, IT IS EXTREMEMLY DIFFICULT FOR US TO KEEP TRACK OF ALL THE INDIVIDUAL REQUIREMENTS OF THE PLANS. EACH ONE HAS DIFFERENT STIPULATIONS REGARDING WHICH SERVICES ARE COVERED AND WHERE THOSE SERVICECS MAY BE PERFORMED, EVEN WITH THE SAME INSURANCE COMPANY, THE PLANS DIFFER DEPENDING UPON WHAT TYPE OF CONTRACT YOUR EMPLOYER NEGOTIATED. PRVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE CAN ONLY PROVIDE QUALITY CARE IFYOU LET US KNOW EACH TIME YOU COME IN FOR SERVICE WHAT YOUR PARTICULAR INSURANCE PLAN'S GUIDELINES ARE. UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS SUCH AS LAB WORK FACILITIES YOUR PLAN HONORS, HOSPITALIZATIONS OR SPECIAL TESTS THAT ARE NOT COVERED, YOU MAY INCUR CHARGES THAT WILL NOT BE COVERED BY YOUR INSURANCE. WITH YOUR COOPERATION, WE WILL BE ABLE TO CONCENTRATE ON CARING FOR YOUR MEDICAL NEEDS.

FINANCIAL RESPONSIBILITY:

Payment in full is expected at the time services are received. NO REFUNDS will be given after the services are rendered (even if we recommend further treatment or evaluation at Emergency Room or Specialists or other facilities). You will receive a bill for the treatment from Northside Primary Care Professional Services for any pending balance. Your insurance carrier will process the claim(s) on an outpatient basis as a **Primary Care** physician office visit. Outpatient services may require co-insurance, deductible and/or co-pay, depending on insurance policy benefits. If your insurance company applies part or all of our treatment charges to your deductible, we can NOT convert that to self-pay charges after it has been billed to your insurance company. Accounts more than 30 days past due will accrue interest at the rate of 8 percent annually. This interest does not apply to deductibles/copayments of Medicare/Medicaid or other governmental programs. **(Accounts under an agreed alternate payment contract will not be considered past due, provided the plan is accepted in writing in accordance with Northside Hospital's Payment Installment Agreement Plan up to one hundred eighty (180) days of service, depending upon the Payment Plan established, with all conditions of the payment plan met.)** Insured patients are required to pay identified co-pay, unsatisfied deductible and estimated co-insurance prior to any elective services unless alternate arrangements are made. Uninsured patients are required to make payment in full prior to any elective services unless alternate arrangements are made.

I authorize Northside Hospital, Windermere Medical Clinic, Canton Primary Care, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by telephone or by cell phone for reasons related to the services I received at our facilities or payment for the services I received at facilities, including but not limited to, debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services.

24 Hour Cancellation & "No Show" Fee Policy: Each time a patient misses an appointment without providing proper notice; another patient is prevented from receiving care. Therefore, Windermere Medical Group reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. We will waive ONE "No Show" fee per patient in any 12 month period. Multiple "no shows" in any 12 month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

I acknowledge receipt of the Notice of Privacy Practices ("Notice") from Windermere Medical Clinic / Canton Primary Care / Northside Hospital, the Northside Hospital medical staff. The Notice provides information about how we and our medical staff members may use and disclose my health information. I have been encouraged to read the Notice in full. I understand that the Notice is subject to change. If we change the Notice, I may obtain a copy of the revised Notice at on our website (www.windermeremedical.com).

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____ _____

PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

Northside Hospital l Windermere Medical Group l Windermere Medical Clinic l Canton Primary Care

Patient Name:_____ DOB:___ __/_____/_____

INFORMED CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

1. I acknowledge and understand that, during the course of the treatment for me or for my child's care, it is likely that various types of routine diagnostic and treatment procedures ("procedures") may be utilized, which are considered necessary techniques for the ordinary care and treatment of my condition(s).
2. While these types of procedures are routinely performed in hospitals and doctor's offices without incident, there are certain risks associated with each of these procedures.
3. The physician or his/her associates or assistants are responsible for providing me with information about the procedures and for answering all of my questions. It is not possible to enumerate each risk for every procedure utilized in modern healthcare. However, the physicians or Providers who practice medicine at Windermere Medical Clinic or Canton Primary Care have attempted to identify the most common procedures, their associated risks and possible alternatives. If I have further questions or concerns regarding these procedures, I agree to ask my (or my child's) physician to provide additional information.
4. I further acknowledge and understand that my (or my child's) physician may ask me to provide a separate informed consent document (for example, for a surgical procedure), as well. The procedures referenced herein may include, but are not limited to the following:

    a. Needle Sticks, such as shots, injections or intravenous injections (IV's). The risks associated with these types of procedures include, but are not limited to, nerve damage, causing tingling or burning, infection, swelling, bruising, infiltration (fluid leakage into surrounding tissue), skin sloughing, bleeding, clotting, allergic reactions or paralysis. Alternatives to Needle Sticks (if available) include oral, rectal, nasal of tropical medications (each of which may be less effective) or refusal of treatment.
    b. Radiographic Procedures, such as x-ray, sonogram, mammogram, CT scans, MRI's, PET scans, boric density scans, ultrasounds and/or other imaging studies. The risks associated with these injuries and/or bruising. Apart from using an alternative type of radiographic procedures or refusal of treatment, no practical alternatives exist.
    c. Physical tests and treatments, such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, rehabilitation procedures etc. which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of procedures include, but are not limited to reactions to the material(s) used, infection, bleeding, discomfort, muscular- skeletal or internal injuries, nerve damage, paralysis, bruising, worsening of the condition and/or refusal of treatment, no practical alternatives exist.
    d. Medications / drug therapy, which may be utilized in the care and treatment of patients. The risk associated with these types of procedures include, but are not limited to, food-drug-herbal interactions, allergic reactions; adverse reactions and both long-term and short-term side effects, which vary from medication to medication. Apart from varying the medication prescribed and/or refusal of treatment, no practical alternatives exist.
    e. Laboratory testing which may be utilized when taking samples of blood, bodily fluids and tissue samples for laboratory analysis. The risks associated with these types of procedures include, but are not limited to, injuries which may occur during the collection of the necessary samples, infections, nerve damage, bleeding, bruising, paralysis, loss of limb, tingling or burning, swelling and allergic reactions. Apart from refusal of treatment, no practical alternatives exist.
    f. Internal tubes, such as catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas etc. The risks associated with these sorts of procedures include but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I consent to and authorize the persons participating in and responsible for my (or my child's) care to utilize the procedures, such as those set forth above, as they may deem reasonably necessary or desirable in the exercise of their professional judgment. Including those procedures that may be unforeseen or not known to be needed at the time that this consent is obtained. This consent shall also extend to the treatment of all conditions which may arise during the course of such procedures including those conditions which may be unknown or unforeseen at the time this consent is obtained.

By signing below, I acknowledge and understand that I have been informed in general terms of the following

- The nature and purpose of the procedures
- The material risks of the procedure(s) and
- The practical alternatives to such procedure(s)

If I have further questions or concerns regarding these procedures, I agree to ask my physician/provider to provide additional information. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the outcome and/or result of any procedure(s). I understand that physician, medical personnel and other assistants participating in the patient's care will rely upon the patient's documented medical history, as well as other information obtained from the patient, the family or others having knowledge regarding the patient, in determination whether to perform the procedure(s) or the course of treatment for the/my patient(s) condition and in recommending the procedure.

Medication Policy Acknowledgement: I agree to allow 2-3 business days for prescription refills. I understand that a follow–up visit may be required from my physician in order to obtain a refill. I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my provider. Narcotics and non-narcotic medications will NOT be phoned in after hours. If you are taking controlled medications from us, for your safety, we will occasionally perform a urine drug screen to make sure there are no illegal substances in your system. Patients may be terminated from the practice with a 30 day notice of noncompliance in the taking of their medication. We will NOT refill prescriptions that have been lost or misplaced. .I must keep all appointments as recommended. Please note that timely appointments by you to keep up with refills are necessary; this is your responsibility. I will not give, trade, or sell medications. The following are conditions for immediate termination from the practice: Altering or forging of a prescription is a felony and will be reported and/or obtaining narcotics from any other physician while under Windermere Medical Clinic's care unless other otherwise specified by the physician. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. Please be aware that if you choose to drive a vehicle you could be charged with a DUI. I will not combine any narcotic medications with the consumption of alcohol.

By signing below, I acknowledge and agree that I have read or had this form read to me and I understand and agree to its contents.

_____ _____ _____

PATIENT / REPRESENTATIVE DATE RELATIONSHIP TO PATIENT