ELITE HEALTHCARE
CENTER

CONSENT FOR SERVICES

The undersigned give consent for Elite Healthcare Center, its authorized representatives, its physicians, providers, and/or Independent Physician Contractors to provide appropriate medical services, including diagnostic and radiologic procedures, administration of medicines, and other treatment and care considered advisable or necessary by the patient's treating physicians and providers.

PERSONAL PROPERTY AND VALUABLES

Personal property and valuables should be given to a family member. I understand that Elite Healthcare Center is not responsible for my personal property or valuables, such as money, credit cards, jewelry, luggage, clothing, dentures, eyeglasses, hearing aids, or other prosthetic devices.

FINANCIAL OBLIGATION

In consideration of the services to be provided by Elite Healthcare Center, and its physicians, providers, and Independent Physician Contractors, the undersigned jointly and severally, agree to pay all charges, deductibles, copayments, and/or coinsurance amounts determined not paid or allowable by health insurance payors. Certain routine services and procedures, which are determine as necessary by the treating physician/provider, may not be covered by Medicare, Champus, Blue Cross and Blue Shield, and other third party payors. I/we agree to pay these non-covered services and/or procedures if ordered and performed by the treating physician/provider Elite Healthcare Center.

I/we agree to make payments according to Elite Healthcare Center credit terms. In the event I/we should default in payment of any of the above charges, then I/we agree to pay all reasonable costs of collection, including a reasonable attorney's fee as might be allowed by law, whether the account shall be referred to a collection agency or an attorney. I/we agree that Elite Healthcare Center and its representatives may contact me/us by telephone at any telephone number associated with my/our account. Elite Healthcare Center and its representatives may also contact me/us by sending text messages or emails, using any email address I/we provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

In the event that I/we cannot keep a scheduled appointment, I/we must provide Elite Healthcare Center with a minimum of 24-hours prior notice. In the event that the office is not open, I/we will leave a message with the after-hours answering service. Failure to provide sufficient notice will result in a $50 fee. This fee cannot be billed to insurance. A deposit may also be required to reserve future appointments.

ASSIGNMENT OF BENEFITS

The undersigns assign payment of authorized insurance benefits otherwise payable to the policyholder, including Medicare and Champus benefits, directly to Elite Healthcare Center or its authorized representatives who provide services. I certify that all information is correct which has been given to apply to payment under Medicare, Champus, managed care, and Blue Cross and Blue Shield, and other third party programs.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned authorize Elite Healthcare Center and its treating physicians/providers to furnish any medical and billing information about this account, including but not limited to the following:

(a) Insurance Billing – Information requested by the insurance company, Medicare, Champus, or other third party payors to support the claim submitted for payment of charges applicable to this account.
(b) Medical Necessity and Appropriateness of Services – Information requested by any utilization and/or Peer Review Organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services or to determine the benefits for related services.

This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, cancer registry treatment and follow-up and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. The revocation shall not pertain to information previously released.

Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONSENT.

_____ _____

Signature of Patient or Patient's Representative Relationship to Patient

Signature of Policy Holder, if different from Patient Relationship to Patient

_____ _____

Date

Witness