Memorial Primary Care
York Heart and Vascular Specialist

1600 Sixth Ave
Suite 105
York Pennsylvania
17403

TEL: 717-849-5576
FAX: 717-718-9972

TREATMENT CONSENT and BILLING AUTHORIZATION

The terms of this Agreement are not negotiable

(please indicate those applicable authorizations, releases, and agreements by placing an X as shown, in the appropriate boxes.)

- ☒ **Authorization for Treatment and Diagnostic Procedures**: I understand that the medical care and diagnostic procedures I receive will be that ordered by my physician, his assistants or designees. I consent to any Memorial Primary Care services rendered at the instruction of my physician and I understand that no guarantee or assurance was made to me as the results that may be obtained. I further understand and have no objections to doctors in training or other Memorial Primary Care approved persons assisting in observing my treatment when the purpose of this is to advance medical education.
- ☒ **Consent for Treatment**: I understand that if there are invasive procedures or surgery to be preformed, I will be required to sign a separate consent, and the procedure will be fully explained to me by the physician. I further understand that Memorial Primary Care is not liable for any act or omission in following the instructions of my physicians. I consent to any X-ray examination, laboratory procedures, anesthesia, or surgical treatment or to any other Memorial Primary Care services rendered under the instruction of my physician. Should my treatment require an implantable device/life sustaining device, I give consent to release my Social Security number to the manufacturer/FDA in accordance with the Safe Medical Device Act.
- ☐ **Medicare Authorization**: "Patients Certification Authorization to Release Information and Payment Request": I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.
- ☐ **Medigap Authorization**: I request that payment of authorized Medigap benefits be made either to me or on my behalf to Memorial Primary Care for any services furnished me by Memorial Primary Care and/or associated physicians.
- ☐ **Medical Assistance Recipient Statement**: I certify that the information is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements or documents or concealment of material facts may be prosecuted under applicable Federal and State laws.
- ☒ **Financial Agreement**: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay Memorial Primary Care in accordance with its regular rates and terms and, if the account is referred to an attorney or agency for collection, to pay reasonable attorney's fees and collections expenses. The undersigned agrees to be responsible for charges not covered by insurance. It is understood that the obligation to pay Memorial Primary Care, and/or any physician providing medical services while I am a patient at Memorial Primary Care may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
- ☒ **Assignment of Benefits**: I hereby assign to Memorial Primary Care and/or any physician providing medical services while I am a patient at Memorial Primary Care all medical benefits payable to me or for my benefit for my treatment. I understand that I am financially responsible for the charges not covered by this agreement.
- ☒ **Authorization for Release of Information**: To obtain payment for services or to provide for continuity of care should I be transferred to another institution or referred to a home health provider, I hereby authorize Memorial Primary Care and/or any physician providing medical services while I am a patient of Memorial Primary Care to disclose my insurance carrier, admitting institution or home health medical provider, portions of my medical record including, but not limited to: medical history and physical, laboratory and X-ray results and diagnosis as they relate to my care and treatment. I recognize that the records disclosed may contain information that is protected by Federal and State law, and I specifically consent to the disclosure of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.
- ☒ **I hereby acknowledge receipt of the Notice of Privacy Practice.**

I have carefully read and fully understand this patient consent and financial agreement, have received a copy thereof and accept its terms.

Signature of Patient	Signture of Person Authorized to Consent for Patient	Relationship to Patinet
Signature of Insured if Different	If Patient is Unable to Sign State Reason and Initial	
Signature of Memorial Primary Care Representative	Date	