AUTHORIZED CONTACTS AND CONSENT

Authorized Contacts

AUTHORIZED CONTACTS are people with whom we may discuss appointments, medical care, account information, etc.

You should know that any names, phone #'s, fax #'s, emails and/or mailing addresses
that you provide are already considered as authorized contacts.
This includes but is not limited to …

Responsible Party Information
Emergency Contact Information
Member Names

List any additional alternative contact names and numbers below that you authorize us to use.

Contact Name	Phone# or Fax#	Relationship	Notes

These authorized contacts remain in effect until revoked in writing.

Consent

I have read the back of this form which explains:

Patient Responsibility
Medical Consent
Assignment of Benefits
Consent for Use & Disclosure of Protected Health Information

I understand and agree to the terms as listed on page 2 of this form.
A copy of Laura Wagner, M.D. Notice of Privacy Practices has been made available to me.
This consent remains in effect until I revoke it in writing.

X_____ _____

RESPONSIBLE PARTY SIGNATURE (Patient or Legal Guardian) **Date**

_____ _____

Print Responsible Party Name **Relationship to Patient**

PATIENT RESPONSIBILITY: (Please read)

The patient or legal guardian is responsible for… providing complete, accurate and current insurance information necessary for billing for each service date; for providing referrals before each service (if required by insurance); for providing information to the payor(s) as needed in a timely manner. Otherwise, the patient or responsible person may be responsible for payment. **The patient or responsible person may be responsible for any collection fees incurred by Laura Wagner, M.D. A late fee may be applied to late bills.**

MEDICAL CONSENT:

I request and authorize my physician and her associates, assistants and staff to provide and perform such medical care, tests, procedures, drugs and other services and supplied as considered advisable by my physician for my health and well being. This may include pathology, radiology, emergency services, and other special services and tests ordered by my physician. I acknowledge that no representations, warranties, or guarantees as to result or cures have been made to or relied upon by me.

ASSIGNMENT OF BENEFITS

Medicare: (if applicable) **(Laura Wagner, M.D. will file your claim for you.)**

I request that payment of authorized Medicare benefits be made on my behalf to Laura Wagner, M.D. for any services furnished me by her. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable for related services. I understand that I am responsible for applicable Medicare Part B deductible and coinsurance amounts as well as any non-covered services.

Medigap: (if applicable)

I request payment of authorized Medigap benefits be made to Laura Wagner, M.D. I also authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine benefits payable for services from this provider. I understand that I am responsible for applicable non-covered services.

Insurance: (if applicable)

I request that payment of any authorized insurance benefits to be made on my behalf to Laura Wagner, M.D. for any services furnished me by that provider. I authorize any holder of medical information about me to release to my insurer any information needed to determine benefits payable for services from this provider. I understand that I am responsible for any co-pay, co-insurance, deductible and non-covered services.

Self Pay: (if applicable)

I understand that I am responsible for payment in full at the time of service unless other arrangements are made with Laura Wagner, M.D.

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I hereby give my consent for Laura Wagner, M.D. to use and disclose **protected health Information *(referred to as PHI)*** about me to carry out **treatment, payment and healthcare operations *(referred to as TPO).*** Laura Wagner, M.D.'s *Notice of Privacy Practices* provides a more complete description of such uses and disclosures. I have the right to review the *Notice of Privacy Practices* prior to signing this consent.

Laura Wagner, M.D. reserves the right to revise its *Notice of Privacy Practices* at anytime. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to Laura Wagner, M.D. Attn: Privacy Officer * Laura Wagner, M.D. * 14377 Woodlake Dr. #111 * Chesterfield, MO 63017 * 314-434-1111

With this consent, representatives of Laura Wagner, M.D. *may call my home* or other alternative location and leave a message on voice mail or in person; *may mail to my home* or other alternative location; *may e-mail to my home* or other alternative location: reference to any items that assist the practice in carrying out TPO, such as appointment reminders, statements, insurance items, information pertaining to my clinical care, including laboratory and pathology results among others.

I have the right to request that Laura Wagner, M.D. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Laura Wagner, M.D.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, Laura Wagner, M.D. may decline to provide treatment to me.**