

BLUE RIDGE CARDIOLOGY & INTERNAL MEDICINE, PA
“Our” BLUE RIDGE MEDICAL GROUP

HEALTHCARE CONSENT AND AUTHORIZATION FORM

NOTICE OF PRIVACY: You will receive a copy of our Notice of Privacy Practices that states how we may use and release your health information. A copy of our Notice of Privacy Practices may also be found on our website: <http://www.blueridgemd.com>. Please let us know if you have any questions about this Notice.

CONSENT FOR TREATMENT/CARE & RELEASE OF INFORMATION: I consent to treatment/care, as deemed necessary, by health care providers of Blue Ridge Cardiology & Internal Medicine, PA (Medical Group Practice). I understand that treatment/care may include a variety of medical services based upon the nature of my condition, including laboratory testing and routine care such as immunizations. I am aware that the practice of medicine is not an exact science and I understand that no guarantees have been made to me about the results of treatments, examinations or procedures.

I consent to the use and disclosure of protected health information about me, including information, if any, regarding HIV status or AIDS, for treatment, payment and healthcare operations. I agree that my medical records may be sent to the doctor or healthcare provider who referred me to this Medical Group Practice and to any health care provider or facility to whom I may be referred by providers in this Medical Group Practice. I give my permission to be photographed and/or filmed for treatment and/or general security purposes.

ASSIGNMENT OF INSURANCE BENEFITS INCLUDING MEDICARE AND/OR MEDICAID: I authorize payment of medical benefits payable to me to be paid directly to Blue Ridge Cardiology & Internal Medicine, PA. I understand that billing of insurance is a service only and not a guarantee of payment. If my insurance carrier requires pre-certification or prior authorization for procedures and/or treatment, I understand that I need to assure the necessary approvals have been received.

I assign to Blue Ridge Cardiology & Internal Medicine Associates, PA all rights, titles and interest in any compensation received or to be recovered from any source as a result of injuries sustained by me (patient), for which I have been treated by Blue Ridge Medical Group. I authorize Blue Ridge Cardiology & Internal Medicine, PA to represent me and act on my behalf regarding any insurance non-payment based on a denial or appeal of the services provided, and I authorize the Medical Group Practice to provide and receive confidential medical and other information on my behalf for such purposes.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR THE ACTIONS ALREADY TAKEN BY THE MEDICAL GROUP PRACTICE OR IN PROCESS. MY SIGNATURE BELOW INDICATES APPROVAL OF THE ABOVE AND THAT I HAVE READ AND UNDERSTAND THIS FORM.

_____ Date _____
Patient Signature

If patient is unable to consent or is a minor, complete the following:

_____ Patient is unable to consent because _____

_____ Patient is a minor

_____ Date _____
Signature of Authorized Person Relationship

_____ Date _____
Witness: Print Name/Signature