AUTHORIZATION

GENERAL CONSENT TO TREATMENT

I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

RELEASE OF INFORMATION

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

ASSIGNMENT OF INSURANCE

I authorize any insurance benefits to pay directly to the physicians providing services to the patient, all benefits due, and payable as a result of services rendered.

ACKNOWLEDGMENT OF RESPONSIBILITY TO PAY FOR SERVICES

I understand that the physician will, as a courtesy, file claims with all insurance carriers. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payer unless there is a specific written agreement between the physician and the patient and the payer.

MEDICARE PATIENTS

Medicare will pay only for services it determines to be "reasonable and necessary". If services that the physician has requested are denied for payment by Medicare, you agree to be personally and fully responsible for those charges.

PATIENT RIGHTS: The Patient, or his or her representative, hereby acknowledges having been provided with information:

□ I have received a copy of Code of Mutual Trust: General Information concerning your rights & responsibilities

Do you have an Advance Directive: □ YES □ NO

□ I would like additional information regarding Advance Directives. □ YES □ NO _____

Staff Initials

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how my medical information will be used and disclosed by NRH is in the "Notice of Privacy Practices", which I should read before signing this agreement. A copy has been provided to me in my registration package and is posted in the clinical site.

I have received and accepted a copy of NRH's "Notice of Privacy Practices". □ YES □ NO

Reason for refusal, if "No_____

CERTIFICATION: I Certify that I have read each of the above statements, they are true and correct to the best of my knowledge, I have had each item explained to me to my satisfaction and that I am the patient or am duly authorized by the patient to sign the agreement and accept its terms.

_____ _____ _____

Patient's Signature/Guarantor/or Authorized Person | Relationship | Date Signed