Alamance Regional Physicians Care

Cornerstone Medical Center
1041 Kirkpatrick Road, Suite 100
Burlington, NC 27215

ACCT#:

DOB

GENERAL CONSENT TO EXAMINATION
Alamance Regional Physicians Care

AUTHORIZATION FOR TREATMENT– ASSIGNMENT OF BENEFITS – RELEASE OF MEDICAL INFORMATION

CONSENT TO EXAMINATION AND TREATMENT:

Knowing that I have a condition requiring medical treatment, I do hereby voluntarily consent to routine diagnostic and therapeutic procedures and medical care by Alamance Regional Physicians Care, my physician, and their assistants and designees. I further understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of the care and medical treatment which I hereby authorized. I further understand that I may be required to relinquish private accommodations in the event they are needed for isolation purposes.

Please check one of the boxes below for minors:

- ☐ **YES** I authorize my minor child to present to appointments without an adult and authorize West Burlington Medical Center to perform necessary services to my minor child which are deemed advisable by the physician, including vaccinations, whether or not any adult is present at the actual appointment.

- ☐ **No** I DO NOT authorize my minor child to present to appointments without an adult and I do not authorize West Burlington Medical Center to perform necessary services to my minor child which are deemed advisable by the physician, including vaccinations, whether or not any adult is present at the actual appointment.

RELEASE OF INFORMATION:

I hereby authorize Alamance Regional Physicians Care to release to the Medicare Bureau, Health Care Financing Administration, or its Intermediaries or health insurers or carriers, any information about me needed for this claim, including medical information relating to my treatment. Only information needed for the purpose of processing any claim for payment of benefits may be released. I also authorize the release of medical and related information about my treatment to the Professional Review Organization responsible for reviewing the medical furnished by this institution. I also authorize the forwarding of copies of information from my medical records to accompany me on a transfer from this institution to another acute care hospital, intermediate care facility, skilled nursing home or nursing home as ordered by my physician. I authorize the release of copies of my medical record for this visit to my attending physician(s). I further authorize inspection of my medical record by the N.C. Department of Human Resources as specified in GS 130-9 (e) (1) and other relative legislation to insure this facility's compliance regarding licensure and certification. I have been further advised that I have the right to object in writing to such release and that my objection in writing may prohibit the inspection or release of my information. This authorization will expire two years from this date; however, I reserve the right to withdraw this authorization at any time.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign and authorize payment directly to Alamance Regional Physicians Care of the benefits payable for Physician service benefits otherwise payable to me including payment of medical benefits, including Medicaid, but not to exceed regular charges for these services. I understand that I am financially responsible to the physician for charges not covered by this assignment.

_____ DATE:_____ _____ DATE:_____
WITNESS PATIENT/REPRESENTATIVE

GUARANTEE OF PAYMENT: The patient agrees to pay and any undersigned guarantor hereby guarantees payment of all charges and expenses incurred for provider services. The guarantor is not relieved of his/her liability by an extension of time granted for the payment of these charges or expenses incurred, nor by the acceptance by the provider of a note of the patient or any third person. The guarantor waives homestead and all other exemptions. In the event legal action is necessary to collect the debt, patient guarantor, or any other parties responsible for payment of servers rendered shall be responsible for "reasonable attorney fees" at 15% of the outstanding balance pursuant to N.C.G.S. section 6-21.2 to the filing of any complain. In the event a Judgment is necessary to collect the debt, guarantor or any other parties responsible for payment of services rendered would be responsible for 18% interest from the date of the breach of payment to date of judgment.

_____ DATE:_____ _____ DATE:_____
WITNESS PATIENT

_____ DATE:_____ _____ DATE:_____
WITNESS PATIENT