Access HealthCare
MultispecialtyGroup

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Access HealthCare Multispecialty Group (Access), the Health Care Financing Administration (HCFA), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate with Access, or if I am a self-pay patient, assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification
In consideration of services provided to me by Access and its care centers, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or underinsured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

I understand that if my insurance has a precertification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

As an Access patient, I voluntarily consent to the rendering of such care and treatment as the Access providers and personnel, in their professional judgment, deem necessary for my health and wellbeing.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and understand I may terminate such visit at any time.

My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my Access provider nor any care center staff has made any guarantee or promise as to the results that may be obtained.

Consent to Call
I understand and agree that Access may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from Access.

I understand that I may voluntarily "opt-in" to receive automated text message communications from Access and its partners by informing my provider's staff or visiting "My Profile" on my Access Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

Consent to Treat

I hereby acknowledge that I have received the Access Financial Policy and Notice of Privacy Practices. I agree to the terms of the Access Financial Policy, the sharing of my information via HIE,* and consent to my treatment by Access providers.

Printed Name of Patient: _____ **Email:** _____

Signature: _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent