FINANCIAL, CONSENT, & AUTHORIZATION

Financial Policy
Payment in full is expected at the time of service unless prior *written* arrangements have been made. As a courtesy to our patients, we will file insurance claims to the insurance carriers with which we participate. Any deductible or co-payment your insurance company requires you to pay is due at the time of service. Please ask a staff member for additional information. Unless prohibited by law or contract, the patient is ultimately responsible for all account balances.

How will you pay for today's visit?

__Cash __Check __Credit Card: (circle one): MasterCard / Visa / Discover

Will you be using any of these plans? __PPO __Medicare __Workers Comp __PIP

__Attorney LOP __HMO __POS __Discount Card *Please let us make a copy of your card.*

Consent to Examination
Your signature below gives your consent for the doctor and staff to examine you and perform diagnostic testing based upon your health history and presenting complaints. After your examinations, the doctor will report his findings to you. Following this "report-of-findings," you will be given a form titled, "Informed Consent for Treatment." Upon signing that form, you will attest that you have been adequately informed of the proposed treatment, reasonable alternative treatments, as well as the risks of treatment and non-treatment. In addition, we are happy to provide you with literature or resources, and spend additional time as necessary. We are always available to answer any questions you may have, and want you to be fully informed as you make decisions about your health care.

Authorization to release information
All of the information you have given is confidential and will not be shared with anyone without your authorization. Your signature below will allow us to provide information to other physicians, reviewers, adjusters, third party payers, or any other agency that may require a copy of medical records or additional reports from the doctor in order to process insurance claims. This may include any medical information pertaining to examination, treatment, work status, or any history events discussed during an office visit. This authorization also includes the release of pertinent medical information to any specialist or facility that Dr. Bronson may refer you to for evaluation or treatment. (See also the HIPAA Notice of Privacy Practices document along with the Consent and Authorization to Use, Disclose, or Release your private health information.)

Assignment of Benefits
Your signature below also authorizes the payment of medical benefits to Bronson Clinic, Inc. for services rendered.

Welcome to the Bronson Clinic! We are happy to be of service to you today. Thank you for completing this form. Your signature indicates that you agree to comply with the Financial Policy, Consent to Treat, Authorization to release information, and Assignment of Benefits as outlined above.

X _____ Date _____
Signature of patient or guardian

If this is an accident or work-related injury, please notify the receptionist.