MOUNTAIN PEAKS
Family Practice

Patient Name: ___________________________________ Date of Birth: __________________

As either the patient or the legally authorized representative of the patient, receiving care at this facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the patient, in partial consideration of health care services to be provided to the patient at Mountain Peaks Family Practice.

Consent for Treatment: I hereby give consent to the facility, its contractors, physicians, and employees to provide health care services to the patient and to administer physician orders for the benefit of the patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and in some cases, to obtain separate consent for some of the services they perform.

Communicable Disease Testing: I hereby give consent to the facility to test the patient as necessary for communicable disease in order to protect the health care workers and the patient.

Release of Information: The facility is required by law to make and keep records of the patient's medical treatment. The facility safeguards those records and it uses and discloses such records and the information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the facility's Notice of Privacy Practices, which may be amended from time to time. I hereby acknowledge that I have received or been offered a copy of the Notice of Privacy Practice Pamphlet. I understand that either the patient or I may ask to see a copy of the current notice at any time.

Assignment of Benefits: Any and all benefits from insurance companies and/or third party payers that are payable to the patient or on behalf of the patient for health care services and related payments for services rendered or provided to the patient are hereby transferred and assigned to the facility for the exclusive purpose of paying for charges associated with the health care services provided to the patient in the facility. I understood and intend that all insurance companies and other third party payers will pay benefits directly to the facility in payment of the facility's charges and the charges of any other health care providers for whom the facility is authorized to bill in connection with health care services provided to the patient.

Financial Responsibility: Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services rendered to the patient in the facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patients and the undersigned, if other than the patient, remain responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. In the event that any unpaid balance is placed with a collection agency or attorney for collection, the patient and the undersigned, if other than the patient, each jointly and severally agree to pay an additional 35% collection fee, reasonable attorney's fees and court fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to the facility. I hereby consent to being contacted by telephone at any phone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf at Mountain Peaks Family Practice or any of it affiliates, agents, contractors or assigns (including but limited to billing companies and/or third party collection agencies), and that the methods of contact my include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages - some or all which may result in data charges. I also consent to receiving emails at any e-mail address provided by me or anymore associated with me or acting on my behalf.

By signing below, either as the patient or as the agent or representative of the patient authorized to execute this document and to accept and agree to its terms on behalf of the patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing.

Signature: ____ Date: ____/_____/____ Witness: ___________________

Cell Phone Number: _____________________________ Email Address: ____