Crossroads Medical Group

LIFEBRIDGE HEALTH

Authorization and Assignment of Insurance Benefits

The undersigned patient or authorized individual acting on behalf of the patient understands and agrees to the following:

1. I authorized payment of medical benefits to the physician(s) rendering service(s).
2. I agree and acknowledge that my signature on this document authorizes my doctor to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on each and every claim submitted for myself and/or dependents. I will be bound by this signature as though the undersigned had personally signed the particular claim.
3. I will pay to the physician any balance due for services rendered. I understand that if full payment is not made on my behalf by my (insurer, legal representation or workman's compensation insurance), I will be responsible for any outstanding balance.

Signature of Patient, Parent/guardian, Guarantor Date

LifeBridge Health Consent to Treatment

1. I am presenting myself as an Outpatient and I voluntarily consent to the rendering of care and treatment as may be ordered by my health care provider, associate or assistant. This includes medical treatments such as x-ray, examinations, laboratory tests and minor procedures my physician/provider may order.

2. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this office.

3. I understand that I have the right to consent or refuse consent, to any proposed procedure or therapeutic course. I also understand that it is customary, absent emergency or extraordinary circumstance, that no procedures which pose a material risk of harm are performed upon a patient unless and until he/she has had an opportunity to discuss them with the physician or other health professional to my satisfaction.

4. I have had the opportunity to discuss this form, and I understand its contents and what it means. I verify that I have seen and/or received a copy of the Patient Rights and Responsibilities and understand its contents.

Signature of Patient, Parent/guardian, Guarantor Date

Witness Date