CAPE FEAR VALLEY HEALTH | HARNETT HEALTH

Patient Name _____ **Date of Birth** _____

Financial Agreements and Authorization for Treatment: I hereby authorize Harnett Health Medical Services and its physicians and such assistants as a physician may designate to furnish and perform on me or the patient stated above ("Patient") such medical care, examination, and treatment as may be ordered by a Harnett Health Medical Services physician in his or her medical judgment and such medical care, examination, or treatment as is reasonable incident thereto. I hereby authorize direct payment to Harnett Health Medical Services of all medical insurance benefits (including without limitation Medicare and Medicaid benefits) to which the Patient is entitled in consideration of services to be rendered by Harnett Health Medical Services to the Patient. I understand that, to the extent permitted by applicable law, I am and I agree hereby to be, financially responsible to Harnett Health Medical Services for charges not covered by this agreement, and I hereby guarantee payment to Harnett Health Medical Services on demand for all such charges. I understand that all co-pays and self-pay monies are collected up front before services are rendered.

Signature _____ Date _____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Authorization to Release Information: I hereby authorize Harnett Health Medical Services to furnish, to the extent permitted by applicable law, any medical information acquired in the course of the Patient's examination and /or treatment to any insurance company, government agencies and their agents, and professional review organizations with which I or the Patient stated above may have insurance coverage or which may be assisting in payment of the medical care provided by Harnett Health Medical Services to me or the Patient stated above. I also hereby authorize Harnett Health Medical Services to release any medical information to any licensed physician, health care provider, or medical facility to which I or the Patient stated above may be referred, admitted, or transferred for further medical care. I understand that I may revoke this authorization by written notice at any time except to the extent that action already has been taken.

Signature _____ Date _____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor

Receipt of Notice of Privacy Practices: I understand and have been provided with a Harnett Health Medical Services' Notice of Privacy Practices, which provides a more complete description of how Patient health information may be used or disclosed. I understand that Harnett Health Medical Services reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from any employee of Harnett Health Medical Services.

Signature _____ Date _____

Please check one: [ ] Patient [ ] Guarantor [ ] Authorized Representative [ ] Parent or Guardian of Minor