Islands Community Medical Services

ICMS

CONSENT TO TREAT AND AUTHORIZATION FORM

Thank you for choosing Islands Community Medical Services, Inc. (ICMS). Please review the form below so we may provide the optimal care for you, bill appropriately, and share your information securely.

Patient Name:_____

1. Consent for Treatment

By signing this form I consent to and authorize ICMS providers to treat me. I understand this could include lab tests, x-rays, education, procedures, dental, or other diagnostic tests. I understand that my provider is available to explain the treatment and I have the right to refuse treatment.

2. Professional Service Insurance Release & Assignment of Benefits

I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me or my dependents by Islands Community Medical Service, Inc. I also authorize payment of benefits directly to ICMS, for services provided to my dependents or me. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered. (A photocopy of this authorization shall be considered valid.

3. Insurance

We participate in many insurance plans. If you are insured by a plan and we do not participate with or do not have an up to date insurance card, payment in full is expected at each visit. When you provide our staff with current and complete information, we bill primary and secondary insurances. Please contact your insurances company with any questions you may have regarding your coverage.

4. Referral

I understand that if my insurance requires a referral from my Primary Care Provider for specialist services and if I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, it will be my responsibility to contact my Primary Care Provider's office the same day and obtain the necessary referral, dated for the date of the service. I also accept full financial responsibility for all charges incurred for services received on the day of service, if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

5. Payment

I accept financial responsibility for payments for all services and products received. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. You may pay by cash, check or credit card.

6. Non-Covered Services

Please be aware that some of the services you receive may be non-covered or not considered reason able or necessary by Medicare or other insurers, for example acupuncture is not a covered service by Medicare. Payment for these services must be paid at the time of your visit. You will be notified in advance for all services not covered.

7. Patient Authorization

I authorize Islands Community Medical Services, Inc. to send copies of my records to other physicians as needed for continuity of care. I understand this is a group practice and other providers may be involved in my care. I agree and understand that a copy of my medical records including AIDS, HIV behavioral health service, psychiatric care and treatment for alcohol or drug use will be included as part of my health information, unless you initial not to disclose on ICMS's Use and Disclosure form. I also agree that Islands Community Medical Services, Inc. can release my medical records to accrediting or regulatory agencies, if those agencies request my records and if the law allows these agencies to see my records.

By signing below, I attest I have read the above and authorize Islands Community Medical Services, Inc. to treat, bill and share my medical information as discussed above. This consent is valid for one year from the date signed.

Patient Signature:_____

Printed Name:_____ **Date:**_____

Guardian Signature (If Minor):_____

Printed Name:_____ **Date:**_____

Relationship to Patient:_____