VIDANT HEALTH™

MRN___________

GENERAL CONSENT TO TREAT/ PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE

The following are the conditions for services provided by the Vidant Medical Group which is affiliated with Vidant Health, Inc. for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Vidant Medical Group and its associated physicians, clinicians, and other personnel for myself or for the undersigned patient whom I am the guarantor. I/we consent to the testing for infections diseases, such as, but not limited to: Syphilis, AIDS, hepatitis, and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and the Vidant Medical Group. **I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits**. I/we understand the Vidant Medical Group can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

I understand that North Carolina Worker's Compensation law provides that written information which pertains directly to a workers' compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to NC ST § 97-27.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I/we have received a copy of the Notice of Privacy Practice. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. The Notice of Privacy Practices may be accessed at www.vidanthealth.com.

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Date and Time	Signature of Patient/(Relationship to Patient) (Parent, Guardian or Legally Authorized Representative)
____________________	______________________________
Clinic Witness	Signature of Guarantor/(Relationship to Patient)