AUTHORIZATION FOR CONSENT FOR TREATMENT AND ASSIGNMENT OF PHYSICIAN BENEFITS

CONSENT FOR TREATMENT

I hereby consent to examination and treatment by Lexington Clinic, PSC, including diagnostic and/or therapeutic procedures ordered by the physician.

As part of the medical or surgical procedures or tests authorized by my doctor or doctors and if so ordered by him, her, or them, I consent to be tested for human immunodeficiency virus infection (AIDS), hepatitis, or any other blood-borne infectious disease for diagnosis or other purposes directly related to medical treatment. If a health care worker is exposed to my blood or bodily fluids, the Lexington Clinic may, at its cost, test my blood for any infectious disease. The Lexington Clinic shall confidentially maintain to the extent provided by applicable law: a) the fact that a blood test is ordered, and b) the results of such tests.

PERSONAL DUE BALANCES

Any accounts not paid in full or on an approved payment plan within 60 days are considered delinquent and may be subject to a delinquent account billing fee of up to 10% of the balance. The Lexington Clinic may access information available through credit reporting agencies and services for the purpose of debt collection. Delinquent accounts which remain unpaid may also be referred to an outside agency.

ASSIGNMENT OF BENEFITS

I authorize direct payment of benefits provided under any health care plan or medical expenses policy due to me or payable on my behalf to the Lexington Clinic. I further authorize release of information required by any third-party payor regarding this claim. I permit a copy of this authorization to be used in place of the original. I acknowledge that any or all of the expenses not paid by my third-party payor, as defined under my plan benefit contract, are my responsibility.

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Applicable to Medicare Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or any other information about me to release to the Social Security Administration and/or to the Medicare Program or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Patient Name: ____________________________ **Account Number:** ______________________

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Date	Signature of Patient or Person Authorized to Consent	Relationship to Patient

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Date	Witness

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