**RALEIGH DURHAM MEDICAL GROUP**

**PATIENT DISCLOSURES AND CONSENTS**

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to Raleigh Durham Medical Group or the physician individually for services rendered to my dependents or me by the physician or a provider under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Raleigh Durham Medical Group is unable to collect from my insurance carrier for whatever reason.

**MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent’s records that these programs may request. I hereby direct that payment of my or my dependent’s benefits be mad directly to Raleigh Durham Medical Group or the physician on my behalf.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I certify that I have received and read a copy of Raleigh Durham Medical Group’s Patient Information Privacy Policy. I hereby authorize Raleigh Durham Medical Group or the physician individually to release any of my or my dependent’s medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

**AUTHORIZATION TO MAIL, CALL, OR E-MAIL:**

I certify that I understand the privacy risks of the mall, phone calls, and e-mail. I hereby authorize Raleigh Durham Medical Group representative or my physician to mall, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Raleigh Durham Medical Group to that effect in writing.

**LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

**CONSENT TO TREAT:**

I hereby consent to evaluation, testing, and treatment as directed by my Raleigh Durham Medical Group physician or his/her designee.

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guarantor Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If different from patient)

**Guarantor Name** (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_