



Hudson Family Practice Inc.

CONSENT FOR TREATMENT

AUTHORIZATION FOR INSURANCE PLANS AND OTHER TREATING PHYSICIANS INVOLVED IN MANAGEMENT OF CARE

INSURANCE AND MANAGED CARE PLANS

Your insurance policy is a contract between you and your insurance company. Therefore, it is your responsibility to know its boundaries. Should your insurance company deny any or all of your charges due to benefit coverage, you are responsible to pay any outstanding balance for services received. If you have a co-pay, your contract with your insurance company requires the co-pay to be paid at the time of your visit. I authorize payment of medical benefits, otherwise payable to me, directly to Hudson Family Practice, Inc. for their services stated above. If your insurance company should pay you directly, you should endorse the check and remit it directly to the physician.

REFERRALS

It is your responsibility to let us know when you have a follow-up appointment with your specialist prior to the date of service so that we can do your referral, if needed. If you have been to the emergency room or urgent care center, we may be required to do a referral. We will need to know the date of service within 48 hours. Most managed care companies do not let us post authorize referrals, unless it is an emergency room visit with a 48 hour notification.

RELEASE OF MEDICAL INFORMATION

By signing this agreement, I authorize the release of any information acquired in the course of my examination and/or treatment to my insurance company, as well as other physicians and therapists involved in my care. I acknowledged that a copy of this authorization is valid as the original.

PRESCRIPTIONS

I consent to the use of my medical information necessary for transmission of prescriptions to the pharmacy and as needed for the coordination of formulary and/or benefits eligibility with my insurance company. I consent to the query of my external prescription history as necessary to manage my healthcare and related services.

By signing this agreement, I request and consent to the services provided by the physicians at Hudson Family Practice, Inc.

Patient Name

Date of Birth

Signature of Patient/Guardian

Date