Authorization to Bill for Services Rendered AND Consent FOR Treatment

I authorize the release of information, including the diagnosis and copies of records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and /or other health practitioners. I agree that this consent constitutes any permission the Associates in Primary Care and medical staff would otherwise be required to obtain under Vermont laws before so using or described in the Associates in Primary Care Notice of Privacy Practices.

I give my consent for examination, diagnostic procedures, medical treatments and surgical procedures including local anesthesia, as prescribed by my provider. I acknowledge that no guarantees have been made to me regarding the results of the examination and /or treatment.

I authorize and request my insurance company to pay directly to the doctor or doctors, group benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or my dependents. I understand that all of my bills will be sent to the responsible party who is named on my account. I understand that if any of the accounts I am responsible for are set to a collection agency, I am responsible for all costs incurred through this action.

I understand that this form gives permission for treatment in accordance with the provider's orders.

I also authorize my insurance company or employer to discuss matters related to the payment of claims with the staff at Associates in Primary Care.

If this is a work related incident/injury, I authorize Associates in Primary Care to release information to my employer as deemed necessary for payment of services rendered.

Print Name

Signature of Patient/Guardian/Loco Parentis Date Witness