Consent and Assignment of Benefits

Consent to Treatment: I, ___________________________consent to the provision of treatment that may include diagnostic procedures and medical treatment by James C. Wasson, MD. I understand special consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provide I may ask my provider not to provide such care. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment.

Signature____Date________________________________

Release of Medical Information: I authorize James C. Wasson, MD / Medical Associates of the Lehigh Valley (MATLV) to release any medical information necessary for my care or treatment, or to process an insurance claim to evaluate medical necessity.

Signature _____________________________________Date__________________________________

Responsibility for Payments and Assignment: My insurance is a contract between the insurance company and myself. I understand that I have full financial responsibility for all professional services rendered. I assume responsibility for any deductible, copay, or other balance not covered by my insurance carrier. I also understand that any balances due that are not paid in a reasonable amount of time will be forwarded to collection and I will be responsible for any cost incurred by the office to retrieve their moneys.
I authorize James C. Wasson, MD, PC/ MATLV to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to LVPG MATLV. Should any insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over these funds to MATLV LVPG. I authorize LVPG MATLV permission to contact the insurance commissioner on by behalf if claims are not paid or processed in 45 days according to state law.

Signature _____________________________________Date__________________________________

Receipt of Privacy Act (HIPPA): I, _____________________________________, acknowledge that I have received a copy of the PHI, "Protected Health Information" from James C. Wasson, MD, PC. I realize that if at any time I have any questions regarding PHI I may contact the office.

Signature____Date________________________________

For patients under the age of 18:

Treatment of a Minor: I, the undersigned parent or legal guardian of _____________________________, do hereby authorize James C. Wasson, MD and his staff to perform any medical or surgical care or treatment which is deemed advisable by the physician in the office or hospital. The consent shall remain in effect until legal age of 18, unless revoked in writing.

Signature _____________________________________Date__________________________________

Printed Name___________________________________