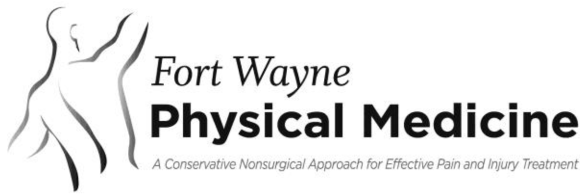

Mark V. Reecer, M.D.
5750 Coventry Lane, Suite 101
Fort Wayne, Indiana 46804
Phone: (260) 436-9337 (866) 436-9337
Fax: (260) 436-9626
www.FortWaynePhysicalMedicine.com

CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for Fort Wayne Physical Medicine to perform diagnostic procedures, render medical care and treatment judged medically necessary by our physicians. I acknowledge that no guarantees have been made to me in regards to the outcome of treatment or procedures. I hereby authorize Fort Wayne Physical Medicine to obtain any medical information from other providers or facilities that they may need to acquire to make informed judgment for the course of my treatment or the decision for procedures. This information may include records relating to treatment of drug and alcohol treatment, mental or psychological conditions, HIV, AIDS and AIDS related conditions or any other unlisted condition.

FINANCIAL POLICY STATEMENT

In consideration of services rendered or to be rendered by Fort Wayne Physical Medicine, I agree to pay for all services performed and ordered by my attending physician. In the event your insurance company requests a refund of payment or denies coverage for your service, you will be responsible for the balance due. Denials based on “Usual and Customary” will be your responsibility pursuant to any managed care contract in place. If this account is unpaid and turned for collections, you will be responsible for all collections cost, including attorney fees. Any questions regarding your insurance coverage needs to be directed your insurance carrier. You will be responsible for all fees incurred for collections of monies owed including collection agency fees and/or court costs.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize release to my insurance company of all information necessary for the payment of benefits. I hereby assign payment of benefits by my insurance company or Medicare to Fort Wayne Physical Medicine.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

A Notice of Privacy (NP) has been made available to me by Fort Wayne Physical Medicine. The NP describes how my health information may be used or disclosed and my rights under the Health Insurance Portability and Accountability Act (HIPAA).

Please initial: **NP accepted** _________ **NP denied** __________

I am giving my consent for release of health or financial information to the following individuals (this does not include copies of medical records or reports):

Name	Relationship	Date of birth
___________________________	_______________________	________________
___________________________	_______________________	________________
___________________________	_______________________	________________

I further authorize Fort Wayne Physical Medicine to communicate with me electronically through e-mail at the following e-mail address: ____

I understand that I have the right to change (in writing) the above named individuals at any time.

____ __________________________________
Patient Printed Name Date

____ __________________________________
Patient / Legal Representative Signature Type of Designation (POA, Custodian)

I further authorize Fort Wayne Physical Medicine to communicate with me electronically through e-mail at the following e-mail address:____