

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing care quality and reviewing competence of health care professionals.

I consent to the use of disclosure of my protected information by all divisions of Coastal Carolina Health Care, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Coastal Carolina Health Care, P.A. including the use of outside medical record auditing consultants to review my protected health care information to conduct medical record audits. I understand that the diagnosis or treatment of me by Coastal Carolina Health Care, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

PLEASE SIGN BELOW:

I hereby authorize Coastal Carolina Health Care, P.A. to administer any treatment as deemed necessary or advisable in the diagnosis and treatment of this patient. This authorization expires in five years.

Signature: _____ **Date:** _____

All Professional Services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment; however, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office personnel. I realize your office files my insurance as a courtesy to me and that I am ultimately responsible for payment of my bill and follow-up with my insurance company if they do not pay promptly.

I request that payment of authorized benefits be made, on my behalf, to Coastal Carolina Health Care, P.A., for any services furnished to me by that association. I hereby authorize any holder of medical information about me to furnish information to insurance carriers, including The Centers for Medicare and Medicaid Services (CMS) and its agents concerning my illness and treatments to determine benefits or the benefits payable for related services. I understand that I am responsible for any amount not covered by insurance. This authorization expires in five years.

Signature: _____ **Date:** _____

I consent to the use of disclosure of my protected information by all divisions of Coastal Carolina Health Care, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Coastal Carolina Health Care, P.A. including the use of outside medical record auditing consultants to review my protected health care information to conduct medical record audits. I understand that the diagnosis or treatment of me by Coastal Carolina Health Care, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

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