St. Mary's Women & Family Care Center
143 Peyton Street
Barboursville, WV 25504

PATIENT'S AGREEMENT

Please Read Carefully

I consent to care and treatment
I consent to examination, treatment and testing as advised by the physician and other providers of St. Mary's Medical Management, LLC. I understand that SMMM is associated with a medical center and a university. I consent to the use or disclosure of my protected health information by the SMMM to diagnosis and treat me, to obtain payment for my bills and to conduct its health care operations and business.

I have received the Notice of Privacy Practices
I have received the Note of Privacy Practices of the SMMM, which tells how my health information may be used and shared. I understand that these instructions reserve the right to revise the notice at any time, and that I can always get the current copy by asking for it.

I agree that payments can be made directly to SMMM
I allow SMMM to directly bill and collect payment from my insurance company, Medicare, Medicaid or other person or entity that pays my medical bills. I assign my rights to receive payment of any insurance to SMMM, including Medicare, Medicaid or other benefits payable from any source. Some insurance companies will not pay for services unless they authorize the service in advance. I understand it is my responsibility to inform SMMM if my insurance policy requires such authorization (sometimes it is called pre-certification).

I agree to pay for the cost of care
I accept full responsibility for the cost of all services that SMMM provides to me. I promise to personally pay all expenses and charges that are not paid by my insurance company or anyone else. I will pay the collection costs, including court cost, if SMMM must sue me to collect my unpaid bill.

I can cancel this agreement
I understand that I can revoke this agreement in writing. This can be done at any time by delivering to SMMM a written statement of revocation, except to the extent that the SMMM have taken action in reliance on this consent, agreement and authorization. I will be financially responsible for any medical services provided before the date of such revocation.

If you have any questions about this document, please ask someone at the front desk for assistance.

I have read this form and I fully understand what I am agreeing to. *(The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorization and financial responsibility discussed above).*

_____ _____

Date Signature of Patient or Legal Representative

STATEMENT OF PATIENT'S LEGAL REPRESENTATIVE OR AGENT

I give the consents authorization made above on behalf of the patient and I have the authority to do so. The patient did not sign because he or she is (check one):

☐ A minor (under 18 years of age)
☐ Mentally or physically unable to understand or sign
☐ Other (describe) _____

I am authorized to sign for the patient because: (for example, being a parent or having medical power of attorney)
_____