Christine Smith, M.D., LLC

8110 Summa Avenue, Baton Rouge, LA 70809

*Read **ALL** information completely then initial and sign all areas indicated.*

Treatment Authorization, Financial Assignment and Acknowledgment

_____ Financial Responsibility (I am responsible for my bill—I will provide correct information and copies of my insurance cards each time I come to the office in order that it can be billed appropriately. I will make every effort I can to pay any balance in full at each visit.)

This is to certify that the information provided to **Christine L. Mills Smith, M.D.** Is true and correct to the best of my knowledge and belief. In consideration of the services rendered to the patient named below, I/we assume responsibility for and guarantee the payment of all Provider charges in accordance with the Provider's current rate. Total charges are payable when rendered. I/we also agree that, except provided by law, I/we shall be responsible for the payment of any provider charges which, for any reason, are not paid by any payer or insurance company. In the event this account is rendered delinquent and requires legal action to resolve payment, I/we agree to pay, in addition to the principal sum due, a fee of thirty three and one third percent (33 1/3%) of the amount due on the account to cover collection agency and/or attorney fees and expenses incurred by the practice.

_____ Consent for Treatment (I consent to be treated.) I/we agree and consent to all procedures, medical treatments, photographs, video tapes, digital or other images deemed necessary by the patient's physician. I/we acknowledge that there is no guarantee, express or implied, as to the results of procedures and medical treatments performed. As a patient of the provider, part or all of your care may be rendered by other practitioners or practitioners in training (physicians, nurses, technicians, etc) under the supervision of the appropriate medical and/or allied staff.

_____ Medical Release & Assignment of Insurance Benefits (I am giving permission for my information to be released for the purpose of billing or insurance purposes outlined and consistent with HIPPAA.)

I/we authorize the provider to release any/all medical records, including diagnoses related to alcohol/drug abuse, mental disorders, HIV/AIDS status and related illnesses and billing information to the Social Security Administration , Medicare, Medicaid (or their various intermediaries), the patient's insurance companies, health maintenance organizations, worker's compensation carriers, employers, alternate care facilities, or persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), including but not limited to _____, when such information is requested for payment utilization review or coverage determination purposes. I/we understand that I/we may revoke this consent remaining in effect until revoked or another Treatment Authorization, Financial Assignment and Acknowledgment form is signed. I/we further authorize any such payer or insurance company to pay directly to the Provider all benefits due and payable as a result of services rendered by the Provider. A photocopy of the Treatment Authorization, Financial Assignment and Acknowledgments shall serve as original.

_____ Notice of Privacy Practices (I have received a copy of NPP)

I/we, individually or on behalf of the patient, authorize the Provider to use and disclose my health information as required for the treatment, payment and healthcare operations as described in the Provider's Notice of Privacy Practices.

_____	_____	_____
Patient's signature OR Legal Representative	**Relationship to Patient**	**Date**