the HandClinic of Austin

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for The Hand Clinic of Austin to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ **Date**_____
Patient/Guardian

Benefit Assignment/Release of Information

I, the undersigned, hereby assign all medical benefits i.e.: Medicare, private insurance major medical benefits, worker compensation and any other health insurance plans to which I am entitled to The Hand Clinic of Austin. A photocopy of this assignment is to be considered as the original. I hereby authorize The Hand Clinic of Austin to release all medical information and records to secure payment for services rendered.

Signature _____ **Date**_____
Patient/Guardian

Financial Policy Statement

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co- insurance are to be made as services are rendered and arrangements are to be made for payments of all amounts not covered by your medical benefits or estimated co-insurance as soon as those amounts are known. If your medical benefits are not paid within sixty days, the balance will be due in full from you.

All co-insurance percentages paid at the time of services are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services by The Hand clinic of Austin, you must promptly remit such payments directly to The Hand Clinic of Austin.

It you are a Workers Compensation patient the above policy does not apply to you. Be advised however, that you may be responsible for your charges if your Workers Compensation is successfully controverted.

If you fail to make timely payments for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ **Date**_____
Patient/Guardian