SANDHILLS MEDICAL FOUNDATION, INC.

PATIENT NAME: _____ DATE OF BIRTH: _____

GENERAL CONSENT TO CARE

I, the undersigned, for myself, minor child, or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care/treatment is provided at any office managed by SMF. This consent includes all medical/behavioral services, diagnostic procedures and treatment rendered under the general or specific instructions of a SMF provider, attending or referral physician, including: ordered exams, X-ray procedures, laboratory test, EKG's, treatment/medication, monitoring, and/or any other tests/procedures deemed necessary. I understand that, as a patient, I am under the direct care of physicians and that the employees, agents and representatives of SMF will carry out the instructions of those physicians. I further understand that SMF does not control the decisions or actions of physicians who provide treatment to me, whether members of the medical center's staff or independent contractors. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations at SMF facilities.

MEDICAL RESIDENT AND CLINICAL STUDENT PARTICIPATION

I understand that SMF has educational affiliations with medical schools and other educational institutions and I consent/agree to a medical resident and/or clinical student participating in my care under appropriate supervision.

RELEASE OF INFORMATION FOR BILLING PURPOSES

I hereby acknowledge and agree that SMF and all providers participating in my treatment may release to my insurers, other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with SMF policies and procedures, any information which may be needed for the purpose of billing, collection or payment of claims for services provided at or by SMF. This information may include, but is not limited to, my identity, medical/psychological evaluations, diagnosis, prognosis and treatment for physical/emotional illness, developmental disabilities, surgical procedures, progress notes and all other information contained in patient care records to the extent that such records are needed for billing or collection of benefits due me from any payer. This authorization will terminate upon payment in full of all claims related to services provided by SMF to me or to the patient for whom I am signing. On an inpatient, outpatient or emergency department basis, I permit a copy of this authorization to be used in place of the original.

ASSIGNMENT OF INSURANCE BENEFITS

I/we authorize SMF to act in my/our behalf as attorney in fact: (1) in the collection of benefits from any responsible third party through whatever means may be deemed necessary, and (2) in the endorsement of benefit checks made payable to myself and/or SMF. I/we hereby authorize payment directly to assign to SMF and provider(s) any and all rights that the patient and I have or to which we may become entitled, under any policy of insurance or any employee welfare benefits plan governed by the Employee Retirement Income Security Act. I/we further warrant and represent that any insurance that we assign is not only a valid insurance, but also in effect, and that we have the right to make this assignment. If eligible for Medicare, I/we request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance, Medicare, Medicaid and any other form of health or welfare benefit.

PAYMENT GUARANTEE

I understand that I am financially responsible to SMF. I expressly promise and agree to pay SMF all such charges which are not paid by my insurance plan, PPO, HMO or other coverage and any applicable co-payments and deductible charges for services that are not covered by the Medicaid or Medicare programs. I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions whereby coverage is subject to a coordination of benefits clause.

Should this account be turned over to a collection agency or to an attorney for collection, I understand and agree that I will be obligated to pay all collection costs, including, but not limited to, reasonable attorney's fees.

By my signature, I understand and agree to the above statements:

_____ _____

Signature of Patient/Other (If other, state relationship to patient here)

_____ _____

Date Signed Witness