☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Specialty Clinic ☐ Hoag at Home

CONDITIONS OF TREATMENT

Name:_____
LAST FIRST MIDDLE

Date of Birth:_____

Consent to Treatment

I hereby consent to all health care treatment and procedures provided by the Hoag entity selected above and affiliates, its physicians, clinicians, and other personnel. Such treatment and procedures may include diagnostic, therapeutic, imaging, and laboratory services.

Financial Responsibility

I hereby assign and authorize direct payment to the Hoag entity selected above and affiliates of any insurance benefits otherwise payable to me or on my behalf for the services rendered. It is agreed that payment to the Hoag entity selected above and affiliates, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment. I hereby attest that the insurance information provided to the Hoag entity selected above and affiliates is accurate, and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage and acknowledge that tests ordered by my physician may NOT be covered by my insurance company.

I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I hereby authorize the release of all information to other physicians and insurance carriers for the purpose of payment for medical services, and further treatment of care by another physician. I further agree that a photocopy of this form shall be as valid as the original.

Payment is due at the time services are rendered. All charges are my direct responsibility. The Hoag entity selected above and affiliates cannot render medical services on the assumption that the charges will be paid by my insurance company. If the Hoag entity selected above and affiliates has problems collecting payment from me, it will also add attorney's fees, collection agency costs and any related fees to my bill.

Patient Portal

The Hoag entity selected above and affiliates utilizes a Patient Portal, which allows me to electronically access my medical information. By signing this form, I hereby request and agree that my medical information and laboratory test results may be provided to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that, unless certain conditions are satisfied, the laboratory test results made available through the Patient Portal will not include test results for HIV, hepatitis, drug abuse, or routinely processed tissues.

By signing below, I acknowledge that I have carefully read, understand, and agree to the terms of the Hoag entity selected above and affiliates' Conditions of Treatment.

Patient/Legal Representative Signature: _____ Date: _____ Time: _____

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____

PATIENT LABEL