AUTHORIZATION FOR TREATMENT AND/OR SURGERY

The patient and others whose signatures are attached below do hereby consent to any and all medical surgical treatments, including anesthetics and operations, which may be deemed advisable by his or her physicians or physician assistant/nurse practitioner serving on the staff of Mid Coast Medical Clinic, the intention hereof being to grant authority to administer and to perform all and singular any examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary.

ASSIGNMENT OF BENEFITS

I/We hereby transfer, assign and convey all my/our rights, title and interest in and all benefits due me/us, if any, by reason of services described in the statements rendered, and as provided for in any contract or policy of insurance under which I/we may be an insured or beneficiary and I direct said insurance company(s) and Medicare to pay directly to Mid Coast Medical Clinic, all of such benefits. I/we also assign my/our causes of action against any and all third parties who may be responsible or liable for the injuries requiring admission to or treatment by Mid Coast Medical Clinic, up to but not to exceed the amount of charges described in the statements rendered. I agree to pay Mid Coast Medical Clinic any remaining balance after insurance payment or denial of coverage under this assignment of benefits. I also authorize the release of any information required in the processing of my healthcare claims.

AUTHORIZATION/PRECERTIFICATION

If my group or private insurance policy requires prior certification, authorization, second opinions, or any other type of utilization review function, I understand that I am responsible for compliance with these and all other terms of my policy.

PATIENT FINANCIAL RESPONSIBILITY

Mid Coast Medical Clinic's election to pursue one or more forms of collection shall not constitute a waiver of its right to pursue other collection measures it deems advisable or necessary. All such remedies shall be cumulative in nature. Venue for collection shall be Wharton County, Texas This agreement shall not require payment by any person in contravention of any state or federal statute, rule or regulation.

ADVANCE DIRECTIVE ACKNOWLEDGMENT

Do you have a living will? ☐Yes ☐No

Would you like information on a living will? ☐Yes ☐No

CONSENT TO TESTING AFTER BLOOD OR BODY FLUID EXCHANGE

I understand, agree, and authorize that in the event a health care worker is exposed to my blood or body fluids, my blood will be tested at no cost to me.

The undersigned certifies that he/she has read this entire document and is the patient, or is duly authorized by the patient or by the law to execute the above agreement and accepts and understands its terms.

MID-LEVEL PRACTITIONER ACKNOWLEDGEMENT

I acknowledge that it is the policy of Mid Coast Medical Clinic to delegate healthcare tasks or general medical services to a qualified physician assistant or nurse practitioner. This allows for more effective utilization of the skills of the physicians. Delegation of such duties is consistent with due regard for the health and safety of our patients and in keeping with sound medical practice.

I fully understand that the physician assistant or nurse practitioner is NOT A PHYSICIAN, and that I have the right to insist at any time on seeing any licensed physician providing services at this clinic.

I further acknowledge that the general medical services provided my by a physician assistant or nurse practitioner are the responsibility of the physicians providing services at this clinic both professionally and legally, for the acts of such allied health personnel rendered during the care and treatment of his/her patients.

I have read the above in its entirety and fully understand the Mid Coast Medical Clinic's policy regarding physician assistants and/or nurse practitioners and do hereby consent to receiving general medical services from a physician assistant or nurse practitioner as may be assigned.

____ ________________________________

Signature of Patient or Legally Authorized Representative Date

____ ________________________________

Signature of Witness Date