DR. GARY BIRDSALL
MEDICAL CLINIC, LLC

102 W 112th Street, Cut Off, LA 70345 Ph: 985-632-5222 Fax: 985-632-4222

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT
Office Practice/Clinic personnel at Dr. Gary Birdsall Medical Clinic, LLC, are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION
I understand that my medical records and billing information are made and retained by this Office Practice/Clinic and are accessible to office personnel. Office Practice/Clinic personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This Office Practice/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Office Practice/Clinic's charges and to any health care provider who is or may become involved with my care. Law requires that this Office Practice/Clinic advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. Office Practice/Clinic personnel may release my general condition to family or friends who inquire about me by name.

ASSIGNMENT OF INSURANCE BENEFITS
I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY
I understand that this Office Practice/Clinic will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY
As consideration for the services provided, I, (the patient or responsible party), _____ guarantee payment for any amount due for such services provided by this Office Practice/Clinic.

CERTIFICATION
I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____	_____	_____	_____
(Patient or Patient's Legal Representative)	(Relationship to Patient)	(Date)	(Witness)

RELEASE OF PROTECTED HEALTH INFORMATION
Information may be released to the following individual(s)

_____	_____	_____	_____
Name	Relationship	Name	Relationship
_____	_____	_____	_____
Name	Relationship	Name	Relationship

I authorize confidential medical messages to be left on:

___ My answering machine at home – Phone #: _____ OR ___ My answering machine at work – Phone #: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A complete description of how your medical information will be used and disclosed by this Office Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted is this Office Practice/Clinic.

I have received a copy of Notice of Privacy Practices.

_____	_____	_____	_____
(Patient or Patient's Legal Representative)	(Relationship to Patient)	(Date)	(Witness)