LINDEN OAKS MEDICAL GROUP
AGREEMENTS AND AUTHORIZATION

Patient Name: _____ DOB: _____

CONSENT TO BEHAVIORAL HEALTHCARE SERVICES

- I, (the Patient signing below, or person signing below who is responsible for consenting on Patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants, or designees, and carried out by physicians or personnel at Linden Oaks Medical Group.
- I understand that I have the right to refuse this care, treatment or other services, as long as refusal is allowed under the law.
- I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments and medications, tests or examinations provided at Linden Oaks Medical Group.

PAYMENT GUARANTEE

- In consideration of the services provided by Linden Oaks Medical Group to Patient, I agree to: i) guarantee payment of all charges that are related to the services provided to the Patient; ii) for all time assign and transfer to Linden Oaks Medical Group all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges; and iii) authorize payment of these benefits directly to Linden Oaks Medical Group.
- I agree that Linden Oaks Medical Group is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be.
- I agree to be fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits.
- Linden Oaks Medical Group provides many services to assist uninsured patients as well as patients who cannot afford the cost of care. I understand that if I have any questions about Edward's financial assistance policy I may ask the office supervisor during the registration process.

FOR MEDICARE PATIENTS

- I certify that any information given by me as the Patient or Patient Representative in applying for payment by Medicare is correct.
- I authorize any holder of medical or other information about Patient to release to Medicare or its agents any information needed for this or a related medical claim.
- I authorize payment of benefits to Linden Oaks Medical Group on the Patient's behalf.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have been offered a copy of Edward's Notice of Privacy Practices. The Notice of Privacy Practices describes how the Patient's medical information may be used and disclosed by Linden Oaks Medical Group and describes the Patient's rights with respect to this medical information.

No revisions or changes to this form by you will be accepted by Linden Oaks Medical Group.

This agreement and authorization form covers services I receive from Linden Oaks Medical Group for a period of 365 days from the date of my signature below, unless revoked by me in writing sooner, or restricted to a shorter period by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Signature of Patient or Patient's Representative (parent, guardian or other representative)	Relationship	Date

Signature of Witness	Printed Name	Date