AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize Family Medical Center at Cinco Ranch (FMCCR) to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay FMCCR directly, I agree to forward to FMCCR all health insurance payments which I receive for the services rendered by FMCCR and its health care providers. I authorize FMCCR or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my insurance plan does not participate in the FMCCR network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by FMCCR and its providers, I agree that I am responsible for all charges for services provided not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse FMCCR for all costs, expenses and attorney's fees incurred by FMCCR to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. As a FMCCR patient, I voluntarily consent to the rendering of such care and treatment as FMCCR providers and personnel, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I have reviewed the clinic policy and hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my FMCCR provider nor any care center staff have made any guarantee or promise as to the results that may be obtained.

Consent to Call, Email & Text. I understand and agree that FMCCR may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from FMCCR. I understand that I may optout of receiving such communications from FMCCR and its partners by notifying FMCCR at 281.392.5005, by informing my provider's staff.

HIPAA. I understand that FMCCR's Privacy Notice is available on my care center's website and that I may request a paper copy at the clinic's reception desk.

I hereby acknowledge that I have received FMCCR's Financial Policy and FMCCR's Notice of Privacy Practices. I agree to the terms of FMCCR's Financial Policy, the sharing of my information and consent to my treatment by FMCCR providers. This form and assignment of benefits applies and extends to subsequent visits and appointments with FMCCR providers.

Patient: _____ Email: _____

Signature: _____ Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent