Sweetwater Medical Associates, PLLC
16651 Southwest Freeway, #100
Sugar Land, Texas 77479
281/494-4900

ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable for the care of the patient named on this form, including, but not restricted to drugs, medications, lab tests or other studies, which may be used, by the physician and/or his/her qualified designate.

I understand and acknowledge that I am solely responsible for providing the valid and correct insurance information for any services provided by Sweetwater Medical Associates before services are rendered. I also understand by failing to supply said information that I will be entirely responsible for payment in full.

Sweetwater Medical Associates, PLLC verifies insurance coverage & files claims as a courtesy to our patients'. Upon verification of patient benefits, every insurance company has a disclosure statement stating there is no guarantee of coverage. Therefore, we too cannot guarantee your coverage. It is your responsibility, as the insured, to confirm with your insurance company as to what is covered and what is not covered, under your policy. By signing below, I acknowledge that any charges, not covered under my insurance, are my sole responsibility.

At the time services are rendered I acknowledge and understand: 1) I am fully responsible for cash payment (if self pay or auto accident), co-payment, deductible and/or co-insurance of such services and agree to pay my bill ***at the time services are rendered unless other arrangements are made with the financial department in advance***. 2) That it is my sole responsibility to provide the correct insurance information for the services rendered on any given day in order for Sweetwater Medical Associates to bill my insurance company. 3) Sweetwater Medical Associates will not bill to any insurance provided after services are rendered. 4) Should I fail to provide the correct information at the time services are rendered, I am ultimately responsible for payment in full, before being issued an itemized receipt, and that no contractual adjustments will be honored.

I authorize Sweetwater Medical Associates to release information as required to my insurance or third party payer (including my employer or my employer's worker's compensation carrier) for the purposes of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and/or mental issues. I also authorize Sweetwater Medical Associates to bill my insurance or third party payer and receive payment directly from them for services rendered.

This authorization shall remain valid for a period of one year or until such as I revoke it in writing. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

Patient Name: _____ Signed: _____
(Patient, Parent or Guardian)

Relationship to Patient: _____ Date: _____/_____/_____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____

_____

_____

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

_____
Name of person or organization

_____
Name of person or organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of person or organization

_____
Name of person or organization

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Sweetwater Medical Associates, PLLC. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
The person or organization to which it is sent may disclose information that is disclosed under this authorization again. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____
Name of patient (Print or type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient