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Benton, AR 72015
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GENERAL AND LAPAROSCOPIC SURGERY
JERRY DIXON M.D., F.A.C.S.

GENERAL CONSENT/ HIPPA/ FINANCIAL AGREEMENT

Patient Name_____ **Date of Birth**_____

_____ **Initial**

Payment Guarantee / Assignment of Benefits

In consideration of services delivered by Jerry W. Dixon, MD, the undersigned understands, agrees and guarantees the following:

- To obtain any prior authorization(s) deemed necessary.
- To assign Jerry W. Dixon, MD all medical benefits payable under my insurance carrier(s) or other parties responsible for my medical bills; and,
- To either A) Pay for all services provided to me by Jerry W. Dixon, MD, or,
  B) Have my spouse guarantee payment for these services by signing the statement below.

I will be financially responsible for services provided by Jerry W. Dixon, MD in the treatment of my spouse,
_____.
(patient's name)

_____ _____ _____
signature ***relationship to patient*** ***date***

- Out-of-network charges;
- Services provided to a minor in my charge and
- Expenses associated with the collection of delinquent accounts, including all reasonable attorney fees incurred in collecting the amount I owe Jerry W. Dixon, MD.

_____ **Initial**

Release of Medical Records Information

I authorize the release of medical record information to those parties that have agreed to maintain the confidentiality of such information pursuant to applicable law. I understand this consent to release medical record information may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on the consent.

_____ **Initial**

Disclosure of Health Information

I agree for Jerry W. Dixon, MD and/or his staff to disclose any health information with regard to my care and treatment to the following individual(s)/family members:

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

_____ **Initial**

Practice and Patient Communication/Contact Release

I agree to have Jerry W. Dixon, MD and/or his staff leave appointment reminders, results, and instruction on my home answering machine, voice mail, cell phone, or work phone.

_____ **Initial**

Financial Policy

I have been provided a copy of Jerry W. Dixon, MD's office financial policy. I have read and understand the policy and have no questions.

_____ **Initial**

Privacy Practice

I have been provided a copy of Jerry W. Dixon, MD's privacy practice form. I have read and understand the form and have no questions.

_____ _____
Signature of Patient/Legal Representative **Date**

_____
Relationship to Patient