Wyoming Health
Medical Group LLC
Wyoming Medical Center

CONSENT FOR DISCLOSURE OF INFORMATION AND ASSIGNMENT OF BENEFITS

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE SERVICES:
I acknowledge receipt of the Notice of Privacy Practices of Wyoming Health Medical Group. I have read the Notice of Privacy Practices and/or I have had the opportunity to read the Notice of Privacy Practices and I understand my rights and obligations with respect to my protected health information. I have also been given the opportunity to view the Patients' Rights and Responsibilities. I consent to the use or disclosure of my protected health information by Wyoming Health Medical Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Wyoming Health Medical Group. I also consent to the disclosure of diagnostic and therapeutic information (including any treatment for alcohol or drug abuse, mental disorders or HIV infections or its manifestations) as may be necessary to determine benefits entitlement and to process payment claims. I authorize release of my medical record as required by accrediting and regulatory organizations. I am aware of the Patient's Rights and Responsibilities.

ASSIGNMENT OF BENEFITS:
I hereby assign to Wyoming Health Medical Group any insurance or other third-party benefits available for healthcare services provided to the patient. I understand that the clinic has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the clinic, I agree to forward to the clinic all health insurance and other third-party payments I receive for services rendered to the patient immediately upon receipt. I hereby authorize any and all third parties and /or entitlement programs responsible for any portion of the patients' bill or services provided by personnel at Wyoming Health Medical Group to make payment directly to Wyoming Health Medical Group. I understand that as an insured or non-insured patient, I am financially responsible for full payment of services provided. In the event legal action is necessary for collection, I agree to pay reasonable attorney's fees and/or court costs. It is further agreed that any credit balance resulting from payment of the insurance or other sources may be applied to any other account owed for services the patient received.

PREAUTHORIZATION:
I understand that it is my sole responsibility to obtain any and all pre-authorizations and to comply with any and all requirements of any insurance company, entitlement program, or health plan for which I am relying for medical coverage.

APPOINTMENT NO-SHOWS:
It is the policy of the clinic to monitor and manage appointment no-shows. Any patient who fails to arrive for a scheduled appointment without canceling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient may be charged $40.00, for failure to show for a schedule appointment. However, the first occurrence of not showing for an appointment will not result in a patient being charge for the no- show fee. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times may be dismissed from the receiving services from the clinic.

PAYMENT:
Payment is due at the time of service. Patients who present verification of third party coverage will be charge the applicable co-payments and deductibles at the time of service as applicable.

______________________________ ______________________________
Signature of Patient/Other Authorized Person Date

______________________________ ______________________________
If patient is unable to sign: Reason Witness