LEXINGTON MEDICAL CENTER

2720 Sunset Boulevard, West Columbia, SC 29169 • **LexMed.com**

Physician Network Authorization/Consent Form

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize and grant permission to the physicians, nurse practitioners, physician assistants, midwives and their assistants and other health care professionals of Lexington Medical Center physician practices to provide reasonable and necessary medical care and treatment considered advisable by my provider. I may be contacted on any cellphone number provided by me for the purposes of conducting business with me or to contact me concerning my account. I consent to the use of automated dialers for that purpose.

SPECIAL PERMISSIONS

Without limiting the foregoing, I additionally authorize and grant permission to Lexington Medical Center physician practices to perform the following tasks unless I expressly object by crossing through and initialing next to the task:

1. To examine, use, store and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body.
2. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C, and HIV.
3. Take and use photographs of me for internal patient identification purposes only. This photograph will expressly not be used for marketing purposes without my expressed consent.
4. Permit students, under the direct supervision of my physician, to observe and participate in my care and treatment. I will be given the opportunity to withdraw consent at any time prior to or during an appointment.

RELEASE AND ASSIGNMENT OF BENEFITS

I authorize and grant permission to Lexington Medical Center physician practices to release any medical information to (1) an insurance company through which I claim benefits and (2) any health care provider involved in my medical care. I authorize and direct my insurers to pay directly to Lexington Medical Center physician practices and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Lexington Medical Center Physician Practices, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled with respect to the care and treatment I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third party insurance policy. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable fees in the event this account is turned over to a third party for collection.

Print Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Responsible Party Signature (if different):_____ Date:_____