# General Conditions of Treatment

THIS AGREEMENT, effective_____/_____/_____ and made this day by and between _____("patient") and Ascent Healthcare Solutions hereinafter referred to as Ascent Sleep & Weight ("provider"), WITNESSETH:

**FINANCIAL AGREEMENT:** The undersigned agrees, where s/he signs as agent or as patient, that in consideration of the services to be rendered to the patient, s/he hereby individually obliges her/himself to pay the account of the provider in accordance with the regular rates and terms of the provider. Should the account be referred to an agency for collection, the undersigned shall pay reasonable collection fees and expenses. All delinquent accounts are subject to bear interest at the legal rate.

**ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION:** In consideration of services rendered, I hereby transfer and assign to the provider and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance. I further assign all right to payment due me for medical and/or surgical services under said policies to provider, my attending/consulting physician. I understand I am financially responsible for the above physician's services. I authorize the provider and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, Health or Hospital Plan.

**MEDICARE PAYMENTS:** (Patient's Certification, Authorization to Release Information and Payment Request) I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**PERSONAL VALUABLES AUTHORIZATION:** I have been informed and understand that the provider will not assume responsibility for my vehicle or any other personal property I may bring and/or keep in the facility during my stay.

**AUTHORIZATION FOR MEDICAL PROCEDURES AND TREATMENT:** I hereby authorize the attending physician and whomever he may designate as an assistant to administer such medications and treatment as is necessary and such operations or procedures as are considered therapeutically necessary on the basis of findings in my case.

**ACCIDENTAL EXPOSURE TO HEALTHCARE WORKER:** I UNDERSTAND AND ACKNOWLEDGE THAT Texas Law provides that if any healthcare worker is exposed to my blood or other bodily fluid, the provider may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of the provider and that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

**NOTICY OF PRIVACY/PATIENT RIGHTS & RESPONSIBILITIES/ADVANCED DIRECTIVES:** I have been given written material about HIPAA Notice of Privacy Practices. I also acknowledge receipt of a written statement regarding my rights and responsibilities as patient, which tells me how to register any complaint I might have.

**AUTHORIZATION FOR VIDEO MONITORING AND PHOTOGRAPH:** I hereby authorize the provider to monitor my treatment as is necessary via video camera and video monitor and to record the session on videotape for the purpose of diagnostic observation of the treatment that has been ordered by my physician. In addition, I authorize the provider to take still photographs of the patient for the purpose of display on the clinical documentation or results as is necessary.

THE UNDERSIGNED CERTIFIED THAT S/HE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

_____

*Signature of Patient or Patient's Agent or Representative*

*Relationship to Patient* _____ *Date*_____

*Witness*_____