Conditions of Service

Consent for Treatment

As the patient or authorized representative of the patient, I consent to inpatient andoutpatient services and procedures performed by West Bend Family Medicine, LLC and its employees.

Patient Rights and Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices and informationregarding Patient Rights. We keep a record of the health care services we provide you. You may ask to see and obtain a copy of that record by contacting our office in writing. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Authorized Persons:

I authorize the following person(s) to have access to my complete medical record and I give my permission todiscuss my care in detail with the person(s) listed below:

- Name_____Relation_____
- Name_____Relation_____

Guarantor Information (for patients aged 18 and younger):

If the patient is 18 years of age or younger, please provide the following information for the guarantor:

- **Guarantor Name**: _____
- **Phone Number**: _____
- **Address**: _____

No Guarantees:

I am aware that medicine is not an exact science and acknowledge that no guarantees or promises have been made to me concerning the outcome or results of any of the procedures, treatment, examination, or care authorized by this consent.

Confirmation and Assignment of Insurance Benefits:

During this period of medical care, I authorize direct payment to West Bend Family Medicine, of any third-party insurance, Medicare, Medicaid or liability benefitsotherwise payable to me.

FINANCIAL AGREEMENT:

By signing below, I agree that I am responsible for payments for any medical services not covered by my insurance and for my assigned portion of covered services. Payment is due within 30 days of the first billing cycle. I understand that if this account is sent to an attorney or a collections agency, I will be obligated to pay reasonable attorney fees, interest at a legal

rate, and collection expenses. Further medical care may not be provided until accounts are up to date.

I understand that I will be billed $50.00 for any scheduled visit that I fail to cancel within 24 hours of myappointment or fail to show up for such appointment. I understand that if I fail to show up for two appointments, I will be dismissed from West Bend Family Medicine.

I have read and understand the above information, have asked questions about anything not clear to me, and am satisfied with the answers that I received. The information I have given is true and accurate to the best of my knowledge.

Patient Name Print_____

Patient Signature (or legally authorized individual)_____

Date_____/_____/_____