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 authorize Lexington Medical Center physician practices to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting 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 express written consent.
4. Permit students/residents, 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.
5. To communicate with me by the cell phone number provided by me, to include text and/or voice, about my health care as well as all business notices which include but are not limited to accounting notifications, billing information and collection messages. I authorize health care communication to include but not be limited to appointment reminders, appointment confirmation messages, post-op or home health care instructions, post-discharge information, results from the lab, and prescription notifications.

## 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 benefit 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 benefit 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 benefit 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 benefit 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:_____