KENNETH L. CRUMP, MD P.C

Lakeview Family Medicine	Crossroad Family Medicine
Phone: (801) 434-7600 Fax: (801) 434-7604	Phone: (801) 766-2121 Fax: (801) 768-2612
Email: reception@lakeviewdoctors.com	Email: reception@lakeviewdoctors.com

CONSENT FOR TREATMENT

I authorize the medical professionals at Kenneth L. Crump, MD PC (CLINIC) to provide medical care, treatment, tests and procedures for my treatment or the treatment of my dependents. I intend this agreement to cover this visit and any future care I or my dependents may seek.

MEDICATION HISTORY AUTHORITY

CLINIC uses an Electronic Health Record (EHR) system which securely imports patient medical history from third party sources (i.e. pharmacies, hospitals, etc.). I authorize CLINIC to transfer my Medical History electronically.

USIIS CONSENT

Lakeview Family Medicine submits all patient immunization records directly to USIIS (Utah State Immunization Information System). I understand that I have the right to opt out of this exchange of information directly through USIIS. If I chose to opt out, I will do so through USIIS and notify CLINIC.

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I agree that I am financially responsible for costs incurred by me, or my dependents. I understand that charges for services provided shall be paid at the time of service. I agree to pay my copay/deductible at the time of service as per my agreement with my health insurance carrier. I understand that CLINIC will submit claims on my behalf and that I am financial responsible for any balance, copay, coinsurance, deductible or any services not covered by my insurance company. I authorize any benefits due me to be paid directly to CLINIC (assignment of benefits).

A finance charge (1.5% per month/APR 18%) will be added to my account when payment has not been received within 30 days from the date of the statement. I hereby agree to pay a service fee of $30.00 for each check or other tender that may be returned to CLINIC by my financial institution. In the event any amounts are referred to a third party debt collection agency, I agree that in addition to any other amounts allowed (interest, court costs, attorney fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount owing as allowed by Utah Code Annotated section 12-1-11. The terms of this paragraph shall apply to any and all amounts incurred by me or by any individual for whom I have legal responsibility, whether such amounts are incurred today or after today.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of CLINIC's Financial policy and agree to pay for said medical services according to such terms.

MEDICAL INFORMATION RELEASE

I acknowledge that I have been given/offered a copy of the NOTICE OF PRIVACY PRACTICES of Kenneth L. Crump, MD PC (CLINIC). CLINIC may release all or part of my or my dependent's medical records to me, and to individuals/companies responsible to pay the charges for services, including my insurance (IE: health, auto, worker's comp, disability) carrier. I further acknowledge that CLINIC may disclose patient information to referring or treating health care providers, and for payment and healthcare operations. I hereby authorize CLINIC to obtain from other health care entities and providers, medical information necessary for treatment, including but not limited to: lab results, diagnostic test reports, films/images, and other clinical information deemed necessary by CLINIC physicians or representatives. I understand that I may inspect my, or my dependents protected health information, request more information, and revoke this authorization as permitted by federal privacy act regulations and in accordance with CLINIC's privacy policy, except to the extent that CLINIC has already used or disclosed my protected health information based on my original request. I also understand that if I chose to revoke this authorization I must do so in writing.

MEDICAL INFORMATION RELEASE TO ASSIGNED PARTIES

I authorize CLINIC to release all or portions of my, or my dependents, protected health information to those indicated below. This authorization is in effect until revoked in writing.

Name: __________________________ Relationship: ____________ Name: __________________________ Relationship: ____________

Name: __________________________ Relationship: ____________ Name: __________________________ Relationship: ____________

OK for testing results and or lab results to be left by Voicemail/Email/Text? ☐ Yes ☐ No

OK to receive automated calls regarding appointment information and or billing information? ☐ Yes ☐ No

I recognize that my verbal permission will be documented in CLINIC's electronic health record also recognize and accepted as if I had given written consent

---

Signature: ___________________________________ **Date:** ______/________/___________

Patient Name: ___________________________________ Date of Birth: ______/________/___________

Relationship (*if other than patient*): _______________________