Name: Date of Birth:

Consent for Provider Services

1. Annual Consent for Services: I consent to the services that may be performed by an Ozarks Family Health, LLC ("OFH") physician/provider ("provider") or facility. I understand that I can withdraw my consent at any time.

2. Legal Relationship between OFH and Provider: I understand that when I am at OFH I am under the care and supervision of my attending provider and it is the responsibility of the OFH staff to carry out his/her instructions. It is the responsibility of my provider to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or clinic services provided to me under instruction of the provider. Otherwise this Consent shall serve to allow my treatment at OFH by its provider.

3. Rules and Regulations: I understand that my visitors and I must obey all OFH rules and regulations. I understand that in the event all rules and regulations are not followed, OFH may pursue corrective action.

4. Notice of Privacy: I acknowledge that I have received a copy of the Notice of Privacy Practices (NPP), which describes when OFH may use or disclose information for treatment, payment and health care operations. The NPP is considered part of this Consent for Provider Services by reference. I understand that this notice is only provided the first time I receive services from OFH and is otherwise available upon request.

5. Personal Valuables: I understand that as a patient, I am encouraged to leave valuable personal items at home. OFH is not responsible for the loss or damage to these items if brought by you to OFH.

6. Demographic Information: I have reviewed the demographic and medical insurance information listed for me and confirm that it is correct. I am aware that I need to inform OFH of any changes as soon as possible.

7. Release of Information: I authorize OFH to release the minimum necessary medical and/or billing information concerning my care, including copies of my medical records, electronically or on paper, for the purpose of ongoing medical treatment and billing for services provided. I acknowledge that this authorization is valid for one year, or until all accounts are settled.

8. Financial Agreement: I agree to accept financial responsibility for all services provided to me by OFH and its providers. I also agree to promptly pay all provider bills, in accordance with the applicable rates and terms, which can be modified by agreement between OFH or provider and my health care insurance company. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it carry interest at the legal rate. OFH will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

Name: Date of Birth:

9. Assignment of Insurance Benefits: I assign and authorize direct payment to OFH and/or its providers of all insurance and plan benefits related to services provided by OFH and its providers. By paying OFH, my insurance company or employer is fulfilling its obligations under my health insurance policy, or my employer is fulfilling its obligations as required by law. However, I also understand that I am financially responsible for charges not paid according to this assignment.

10. Independent Contractor/Providers: I understand that separate bills may be sent for professional services from non-OFH providers such as laboratories, radiologists and pathologists, in addition to the OFH bill.

11. Medicare Assignment: I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize OFH to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

12. Phone Calls: I authorize OFH and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to OFH from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages. I agree such contact will not be "unsolicited" for purposes of local, state or federal law.

13. Patient Self Determination Act:

I have an Advance Medical Directive? Yes No (Please circle one.)

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute and accept the terms thereof. A copy of the executed form is available upon request.

Date: _____ Time: _____ Signature: _____

If signed by other than patient, indicate relationship:_____

Witness:_____ _____