TITAN
T-CENTER & WEIGHT LOSS

Patient name:	
DOB:	Today's date:

GENERAL CONSENT FOR MEDICAL TREATMENT/HEALTHCARE

POLICIES AND PROCEDURES:
We will collect your deductible, co-insurance, co-payment and/or non-covered charges at the time of visit. Please be advised that this is NOT a guarantee of benefits. The amount collected at the time of service is based on a verification of benefits and is subject to change after the claim has been submitted and processed.

- *Insurance Denial:* If your insurance company denies your charges, you will be expected to pay balance within 30 days or call our billing department for payment arrangements.
- *Managed Care:* (HMO, PPO): Your co-pay or deductible will be collected at time of service.
- *Self –Pay Patients:* Patients without medical coverage are expected to pay at time of service.

If you have any questions regarding our financial policy, please contact our billing department at (832) 738-1913. _____ (Initial)

CONSENT TO OBTAIN PATIENT HISTORY: I understand that Titan shall maintain documentation of the medical care received. This medical record will typically include symptoms, health conditions, results of physical exam and diagnostic tests, medications, a treatment plan; as well as demographic and photographic identifiers. Such information is protected health information (PHI) and can be used, shared or disclosed only for the purpose of treatment, payment, and healthcare procedures. _____ (Initial)

HIPAA/ NOTICE OF PRIVACY PRACTICE: I understand that the patient's health information is private and confidential. I understand that Titan may disclose PHI to provide care to the patient and handle billing & payment. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternative locations. I authorize Titan to use and/ or disclose my PHI. _____ (Initial)

AUTHORIZATION TO USE OR DISCLOSE MEDICAL INFORMATION: I authorize Titan the use or disclosure of my individually identifiable health information as described: complete health record, progress notes, laboratory tests. This information is to be disclosed to: Titan T-Center & Weight Loss, 2785 Gulf Fwy S., Suite 115 League City, TX 77573 phone (832) 738-1913, fax (832) 738-1176 _____ (Initial) OR Titan T-Center & Weight Loss, 347 E. Parkwood, Suite A, Friendswood, TX 77546 _____(Initial) OR Titan T-Center & Weight Loss, 25701 I-45 North, Suite 5, The Woodlands, TX 77380_____(Initial)

CONSENT FOR TREATMENT: I hereby voluntarily consent to care, testing, treatment and any services performed by healthcare providers at Titan. I understand that I have the right to refuse any proposed care, testing or procedures. I have the right to ask questions and discuss concerns with my healthcare team. _____ (Initial)

ADVANCE DIRECTIVES: Adults 18 and older have the right to designate a patient representative to make medical decisions if they lose individual decision-making capacity. I understand that this is available to me if needed. _____ (Initial)

LABS: I authorize Titan to run labs ordered by the prac oners. I understand I may receive an explanation of benefits from insurance company. This is a statement sent via your health insurance company explaining what was paid on their behalf. _____ (Initial)

MEN: I understand that I need a complete H&P. I understand that all patients > 40 with PSA > 0.6 need a digital rectal exam. I have the right to refuse but aware of the risk of HRT stimulating an undiagnosed prostate cancer. _____ (Initial)

WOMEN: I understand that I need a complete H&P. I understand that being pregnant is a contraindication to certain services at Titan. Should I be pregnant, there is risk to my unborn child. I can deny pregnancy testing at any time. I release liability to the healthcare team based on this decision. _____ (Initial)

PATIENT RIGHTS & RESPONSIBILITY: I acknowledge that my healthcare is a partnership between Titan and me. I understand that my provider will verbally inform me of side effects, allergic responses and potential complications that may occur. I have the right to request educational handouts regarding care. I agree to actively participate and accept responsibility to my healthcare. I understand that much of the success of the program will depend on my efforts. _____ (Initial)

(Patient Signature) _____ (Clinical witness) _____

(Today's date) _____

Due to our policy we require a credit card on file. No transaction will be make without your notification. Card on file gives our regulars the convenience of house accounts, so transactions are quick and seamless.

Account type: (Please check) _____ VISA _____ MasterCard _____ AMEX _____ Discover

Cardholder Name _____

Account number _____

Expiration Date _____

Signature _____

I authorize the above business to charge my credit care indicated in this authorization form according to the terms outlined above. This payment authorization is for the service/goods received. I certify that I am an authorized user of this card and that I will not dispute the payment with my credit card company.