SACRED CIRCLE HEALTHCARE
A HEALTH DIVISION OF CTGR

660 South 200 East Ste. 250 Salt Lake City, UT 84111
Phone: 801-359-2256 Fax: 801-364-4392

PATIENT CONSENT FORM

CONSENT TO MEDICAL SERVICES

_____ **(Patient Initials)** I consent to laboratory procedures or other services rendered to me as ordered by my physician. This consent includes the testing for blood borne infectious diseases, including but not limited to Hepatitis and HIV (Human Immune Deficiency), if a physician orders such tests for diagnostic purposes.

ASSIGNMENT OF BENEFITS

_____ **(Patient Initials)** This assignment of benefits allows the health care facility and/or facility-based physicians to be paid directly by my health insurance carrier or other health benefit plan for the laboratory services, the pharmacy services, the healthcare facility and/or facility-based physicians provide to me. In return for the services rendered and to be rendered by the facility and/or facility-based physicians all right, title, and interest in all benefits payable for the laboratory services rendered, which provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the health care facility and/or facility-based physicians an independent right of recovery against my insurer or physicians to pursue any such right of recovery. In no event will the healthcare facility and/or facility-based physicians retain benefits in excess of the amount owed to the healthcare facility and/or facility-based physicians for the care and treatment rendered during my visits.

PAYMENT AGREEMENT

_____ **(Patient Initials)** The patient/responsible party or legal guardian obligates him or herself to the payment of practices account incurred in accordance with the regular rates and terms of the practice at the time of discharge. If the patient/responsible party fails to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, the patient/responsible party shall pay a 29% collection fee and all court costs and attorney's fees.

MEDICARE PATIENT CERTIFICATION

_____ **(Patient Initials)** I certify that the information given by me in applying the payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

_____ **(Patient Initials)** I agree that, in order for Sacred Circle Healthcare, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Sacred Circle Healthcare or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation or wireless, I have provided or Sacred Circle Healthcare or EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

CERTIFICATION

I hereby certify and state that I have read an been given the opportunity to ask questions about this Patient Authorization, I fully understand this Patient Authorization and that I have signed this Patient Authorization knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any laboratory procedure or other services and I have signed this document without inducement, other than the rendition of services by the healthcare facility and/or facility-based physicians.

Patient/Parent/Guardian/Patient Representative Signature:	**Date:**
Patient/Parent/Guardian/Patient Representative Name (Printed):	**Date:**
Witness Signature:	**Date:**