Lynch Surgical Group, P.C.
1818 N 6th St.
Terre Haute, IN 47804
(812) 232-1123
The practice of Lynch Surgical Group, P.C. and its affiliates and its employees further referred to as "the practice".

CONSENT TO TREAT:

I request and give consent to the practice to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial for my health and wellbeing. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or upon by me.

This is where the patient signs

X_____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS:

I authorize the practice to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to the practice on my behalf.

This is where the patient signs

X_____

MEDICARE CERTIFICATION:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the practice to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to the practice, on my behalf.

This is where the patient signs

X_____

FINANCIAL AGREEMENT:

I understand accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. The practice may assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to affect collection of this account or future outstanding accounts.

This is where the patient signs

X_____

Consent to Email, Text, and Phone Communication:

I authorize the practice to use my home or mobile phone number to call regarding appointments, treatment, insurance and my account.

If at any time I provide an email or mobile phone number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or Text Messages to that mobile phone number from the practice. I understand that this service is offered free of charge, however, standard text messaging rates from my mobile carrier may apply.
Email and Text Messages are not secure platforms. You have the right to withdraw your consent at any time by written request to the practice address above

This is where the patient signs

X_____

Patient Portal:

You are invited to join our practice's patient portal. If you choose to join, you can access health information, view and pay bills online, and communicate electronically with the practice.
If you want to join, please ask a staff member, and they will get an email address from you. We will then send an email invite for you to join the portal.
If you do not request to join, then that will be taken as consent that you do not want to receive access to health information via our patient portal. If you want to join later, please ask, and we will send the invitation.
By signing below, you acknowledge that you have been given the option to join our patient portal.

This is where the patient signs

X_____

NO SHOW POLICY

Patients will be charged a $100 "No Show/Cancellation" fee for the following reasons:

1. If you do not show up for your scheduled procedure
2. If you arrive late for your procedure (greater than 15 minutes after the assigned arrival time, which is usually 90 minutes before the procedure)
3. If you cancel your procedure less than 5 business days before the procedure

These "No Show/Cancellation" fees are not covered by insurance and are therefore the sole responsibility of the patient.
In the event of an emergency, Office Management will consider the circumstances and may grant an exception.

This is where the patient signs

X_____

RELEASE OF INFO: I give my authorization for protected health information to be released to the person(s) listed below. Enter Name and Relationship for each person.

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