

Southwest Ohio Pain Management (SWOPM)/Desert Valley Physicians (DVP)
5700 Gateway Blvd., Suite 100B
Mason, OH 45040

MEDICAL TREATMENT AGREEMENT

Patient or someone acting for the patient agrees to the following terms for patient care:

1. **MEDICAL TREATMENT:** Patient will be treated by his/her attending doctor or specialist. Patient authorizes SWOPM/DVP to perform services ordered by the doctors. Special consent forms may be needed. Many doctors and assistants (such as those providing x-rays, lab tests, and anesthesiology) may not be SWOPM/DVP employees and are responsible for their own treatment activities. Patient consents to the treatment to be provided by those doctors and technicians. SWOPM/DVP may develop and establish certain criteria which will automatically trigger the performance of special tests which patient agrees may be performed without any further separate consent.
2. **GENERAL DUTY NURSING:** SWOPM/DVP provides only general nursing care. If the patient needs special or private nursing, it must be arranged by the patient or by the doctor treating the patient.
3. **MONEY AND VALUABLES:** SWOPM/DVP will not be responsible for any loss or damage to items. SWOPM/DVP will not be responsible for loss or damage to items such as glasses, dentures, hearing aids and contact lenses.
4. **RELEASE OF INFORMATION:** SWOPM/DVP or a treating provider may disclose all or any part of the patient's medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, OR CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION), to the following:
 - a.) **THIRD PARTIES:** Including but not limited to any person or corporation, or their designee, which may be liable under contract to SWOPM/DVP, any other party, the patient, a family member, or employee of the patient, for medical payment of all or part of a provider's charges, such as insurance companies, worker's compensation payers. SWOPM/DVP or medical service companies, welfare funds, governmental agencies or the patient's employer; quality assurance and peer review committees, subcommittees, ad hoc committees, or consultants; utilization review organizations; Medicare review organizations; SWOPM/DVP accrediting surveyors; treating physicians; and SWOPM/DVP and treating physicians professional liability insurance carriers.
 - b.) **OTHER HEALTH CARE PROVIDERS:** Information may be released to other health care providers in order to provide continued patient care.

I understand the authorization granted in items 4, a and b may be revoked by me at any time, except to the extent to which action has been taken in reliance upon it. The authorization will stay in effect as long as the need for information in items 4, a and b exists.

I have read and understand this Admissions Agreement, have received a copy and I am the patient, the parent of a minor child or the court appointed guardian for the patient. I am authorized to act on the patient's behalf to sign this Agreement.

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|---------|---------|-----------------------|---|
| Witness | Patient | Parent of Minor Child | Court Appointed Guardian (Please circle correct title) |
| Date | Time | | |

MEDICAL POWER OF ATTORNEY, I appoint: _____

| | |
|---------|-------|
| Address | Phone |
|---------|-------|

as my agent to act in all manners relating to my health care, including full power to give or refuse consent to all medical, surgical and SWOPM/DVP care. This power of attorney shall be effective upon my disability or incapacity or when there is uncertainty whether I am dead or alive and shall have the same effect as if I were alive, competent to act for myself.

| | |
|---------|---------|
| Witness | Patient |
|---------|---------|

FINANCIAL AGREEMENT

I agree that in return for the services provided to the patient by SWOPM/DVP or other health care providers, I will pay the account of the patient, and/or prior to discharge make financial arrangements satisfactory to SWOPM/DVP or any other providers for payment. If an account is sent to an attorney for collection, I agree to pay reasonable attorney’s fees and collection expenses. The amount of the attorney’s fee shall be established by the Court and not by a jury in any court action. A delinquent account may be charged interest at the legal rate. If an account is sent to an agency for collection, I agree to pay collection fees, equating up to 50% of the outstanding balance at the time the account is placed with the agency.

I understand that my health insurance is a contract between me and the insurance carrier and the provider. I understand that I am ultimately responsible for any fees rendered to me that are not covered by my insurance company. I agree to pay my portion of fees at the time treatment is rendered by SWOPM/DVP. This office accepts billing for individual or group policies, personal injury claims and authorized worker’s compensation.

I agree that SWOPM/DVP shall be appointed as my agent to endorse drafts or any checks for payment of my bill for medical services rendered.

When paying by check towards any amount that may be due by the patient, I understand that if the check is returned unpaid, the checking account will be debited electronically for both the face amount on the check and a \$25.00 service charge. This will be in addition to any charges assessed by my financial institution as a result of the dishonored check.

If any signer is entitled to benefits of any type whatsoever under any policy of insurance insuring any patient, or any other party liable to patient, that benefit is hereby assigned to SWOPM/DVP or to the provider group rendering services for application on patient’s bill. HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT’S BILL.

IN GRANTING ADMISSION OR RENDERING TREATMENT, SWOPM/DVP AND OTHER PROVIDERS ARE RELYING ON MY AGREEMENT TO PAY THE ACCOUNT. EMERGENCY CARE WILL BE PROVIDED WITHOUT REGARD TO THE ABILITY TO PAY.

Patient

Other Party Agreeing To Pay

Witness

Relationship To Patient

Date