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4201B Anderson Ave, Suite 1 . Manhattan, KS 66503 . 785/539-5555

**CONSENT FOR TREATMENT**

I understand that I may have a condition requiring diagnostic procedures, physical examination, and/or medical treatment. I hereby voluntarily consent to such procedures, physical examination, and such clinical treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided by Maximum Performance.

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

The undersigned hereby authorizes Maximum Performance to disclose the patient's medical information to the referring physician, if any, and to the patient's health plan (such as Medicare, Medicaid, or insurance company) for the purposes of processing claims and to obtain payments on the account for services provided to the patient.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I acknowledge that Maximum Performance has presented and made available to me their Notice of Privacy Practices for protected health information.

**MEDICARE RELEASE**

**MEDICARE NUMBER:** \_\_\_\_\_

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Maximum Performance to release to the Centers for Medicare and Medicaid Services and its agents, any information needed to process my Medicare claims.

**MEDICARE SUPPLEMENTAL INSURANCE**

The undersigned hereby authorizes Maximum Performance to bill for Medicare Supplemental Insurance payments for my medical care. I understand that \_\_\_\_\_ needs information about me, and my medical condition, to make a decision about payment. I request the above named carrier to make payment of authorized Medicare Supplemental benefits on my behalf to Maximum Performance for any services furnished me and authorize any holder of medical information about me to release to the above named carrier any information required to determine and pay these benefits.

**ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby agrees to assign and authorize payment of medical benefits directly to Maximum Performance.

**FINANCIAL AGREEMENT**

The undersigned agrees, in consideration of the services to be rendered to the patient, to pay Maximum Performance in accordance with the regular rate and office's payment policy.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT, TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date