MCG
Medical Associates

Patient Name _____ **Patient Number** _____

CONSENT FOR TREATMENT

I am presenting myself for treatment at the MCG Medical Associates operated by The Medical College of Georgia Physicians Practice Group Foundation (PPG), and I voluntarily consent to the rendering of medical care such as diagnostic procedures, surgical and medical treatment, blood transfusions, and any other procedures by employees and agents of the Clinic, and by its medical staff, or their agents, as may in their professional judgement be deemed necessary or beneficial.

I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of examinations or treatment of my condition.

I understand that in addition to Clinic personnel and my attending physician, students, residents, interns, and fellows at the Clinic will be involved in my care and treatment. I authorize the Clinic and my attending physician to permit the presence of such observers as they deem fit, in the interest of medical education and knowledge, while I am undergoing any medical procedure, examination and treatment.

ASSIGNMENT OF INSURANCE BENEFITS

In connection with the care provided, I, whether signing as agent or as patient, agree to assign to PPG all medical insurance benefits otherwise payable to or on behalf of me or the patient not to exceed the total fees associated with the care. I understand that this means the physicians will receive direct payment from the insurer. I further agree to furnish a notice of claim, if required, promptly to the insurer or to my employer. I further agree to be responsible for the balance of my medical bills not paid by insurance or my employer or other sponsor. In the event I am unable to pay the balance in full, I agree to pay the amount established by PPG for the fees.

CONSENT TO RELEASE INFORMATION

I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, PPG may disclose any information in the patient's records to any persons or corporation that is or may be liable for the charges. Also, to provide for continuity of care, I consent for MCG Health, Inc. and PPG to release my records to each other.

I certify that I have read the foregoing and I am the patient or I am authorized to consent on behalf of the patient.

_____

Patient's Signature or Mark (Date) Witness

The above consent is given on the patient's behalf because the patient is a minor (age ___) or is unable to consent for him/herself for the following reason(s):

My relationship to the patient is: _____

_____

Signature of Parent, Guardian, Authorized Person or the Patient (Date) Witness

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