ST. DOMINIC MEDICAL ASSOCIATES, LLC
CONSENTS AND AUTHORIZATIONS

Prescription History: The undersigned authorizes St. Dominic Medical Associates, LLC ("SDMA") obtaining the Patient's prescription drug history from pharmacy networks for safer patient outcomes.

Release of Medical Information: The undersigned authorizes SDMA and its physicians providing to the Patient's insurance companies and outpatient benefit programs the Patient's health information as needed to process insurance claims. The undersigned understands SDMA participates in various health programs with insurance carriers and may be required to submit the Patient's health information to the Patient's insurance carriers or outpatient benefit programs. The undersigned authorizes SDMA providing the requested information related to the health program to the Patient's insurance carriers or outpatient benefit programs.

Release to Work or School: If requested by the Patient's work or school, the undersigned authorizes SDMA providing the Patient's work or school a written excuse.

Pay Insurance Benefits: The undersigned assigns payment directly to SDMA for all insurance and similar benefits otherwise payable to the Patient by virtue of medical treatment provided by SDMA, but not to exceed SDMA regular charges for medical treatment. The undersigned understands the Patient is financially responsible for charges not covered by insurance, and the undersigned agrees that the Patient shall be responsible for all charges incurred, regardless of the status of medical insurance or similar benefits.

Consent for Treatment: The undersigned authorizes and consents to SDMA and its physicians furnishing medical and surgical treatment that the Patient's physicians consider necessary and proper in the treatment of the Patient. This treatment may require diagnostic procedures, including but not limited to, laboratory tests, drawing blood for those tests, x-ray/imaging and electrocardiograms.

Consent for Retirement of X-Ray Film/Graphic Data: The undersigned authorizes and consents to SDMA retiring the Patient's x-ray films and any other graphic data, four (4) years after they are generated or created if the written and signed findings of a radiologist or other professional who has interpreted the x-ray film or graphic data is maintained in the Patient's medical record.

Consent for Blood Sample: In the event anyone involved in the Patient's care has an exposure to blood and or bodily fluids, the undersigned approves and consents for Patient to provide a blood sample to be used to detect the presence of blood borne pathogens or diseases which may include Hepatitis B, Hepatitis C and HIV.

Payment Terms: The undersigned understands that payment in full is due on the date of treatment for all services provided and the undersigned agrees to pay all charges for the Patient. The undersigned acknowledges that a $40 fee will be added to the Patient's account for returned checks. SDMA DOES NOT ISSUE REFUNDS TO PATIENTS WITH A CREDIT BALANCE OF LESS THAN $5.00 AND WILL NOT ISSUE INVOICES FOR BALANCES OWED OF LESS THAN $5.00. AFTER 90 DAYS, THESE BALANCES WILL BE WRITTEN OFF BY SDMA AND ANY CREDIT BALANCES OF PATIENT WILL BE RETAINED BY SDMA. THE UNDERSIGNED UNDERSTANDS AND AGREES TO SDMA'S POLICY REGARDING CREDIT BALANCES OF LESS THAN $5.00.

Valuables: The undersigned (individually and on behalf of Patient) releases SDMA and its employees from any responsibility due to loss or damage to any of the Patient's valuables while on the SDMA's premises.

Release of Information: Unless otherwise authorized by this document or by law, SDMA will only release the Patient's health information to the undersigned. The undersigned may specify below others to whom the Patient's health information may be released (for example, the Patient's spouse, son, daughter, sibling, caretaker, and friend). This health information would include, but not be limited to, medical information, billing, and other protected health information.

Name _____ Relationship _____ Name _____ Relationship _____

Patient's Name (print): _____
Patient Signature: _____ Date: _____

As the patient's representative, I am authorized to sign this document on the Patient's behalf.

Patient's Representative Name and Relationship (print): _____
Patient's Representative Signature: _____ Date: _____