SETH W. WHARTON, M.D.
NEUROLOGY
DIPLOMATE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I consent to the use or disclosure of my protected health information by Seth W. Wharton, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Seth W. Wharton, M.D.

Payment Agreement: I understand that Seth W. Wharton, M.D. will submit to my insurance company, this includes Medicare and Medicaid patients, and dual covered patients, the information necessary to secure payment of benefits for covered services. I understand that this will require accurate and complete information from me. I understand that if an insurance referral is required for payment of insurance benefits, it is my responsibility to obtain the referral from my Primary Care Provider **PRIOR** to my visit with Seth W. Wharton, M.D. If the information I provide is deficient in a way that prevents payment of insurance benefits, I agree to assume **FULL** responsibility for payment. I also understand that I am financially responsible for all charges including deductibles, co-payments, no-show/cancellation fees and services not covered by my insurance contract, and agree to timely payment of my obligations. If uninsured, I agree to **FULL** payment at the time of service, unless I have already set up another agreement with the office **PRIOR** to my visit.

I have the right to revoke this consent, in writing, at any time, except to the extent that Seth W. Wharton, M.D. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Medicare Billing Authorization (applies to Medicare patients only)

I certify that the information I have provided in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made to Dr. Seth W. Wharton. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Seth W. Wharton, M.D.'s Office Policies:

Rescheduling policy: Please let us know as soon as possible if you need to reschedule an appointment, as we would like to give the unused slot to another patient. **Any New Patient** who reschedules with less than **48 hours notice will NOT be rescheduled**. **Any patient** who **repeatedly** does not keep their appointments or provides us with inadequate notice of a cancellation are subject to dismissal.

Payment policy: Any account that results in a personal balance has 30 days to pay that balance in full. Any personal balance that is outstanding after that 30 day period will be subject to a monthly 1.5% interest fee or a $5.00 fee, whichever is greater.