Patient name: _____
Date of birth: _____

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, TRISTAR MEDICAL GROUP may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge TRISTAR MEDICAL GROUP may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to TRISTAR MEDICAL GROUP any insurance or other third-party benefits available for health care services provided to me. I understand TRISTAR MEDICAL GROUP has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to TRISTAR MEDICAL GROUP, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to TRISTAR MEDICAL GROUP by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for TRISTAR MEDICAL GROUP, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that TRISTAR MEDICAL GROUP or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or TRISTAR MEDICAL GROUP or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: _____ Date: _____

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

☐ Spouse
☐ Parent
☐ Legal Guardian
☐ Guarantor
☐ Healthcare Power of Attorney
☐ Other (please specify) _____