CONSENT FOR MEDICAL TREATMENT: I hereby authorize the personnel of Advanced Medical Management, (AMM) Multi-Specialty HealthCare,(MSHC) Harford County Ambulatory Surgery Center (HCASC) and Baltimore Work Rehab (BWR) (hereafter referred to as AMM and Affiliates) and members of its medical staff to render to the patient whose name appears on this form care as they deem necessary and appropriate.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize AMM and Affiliates to release, via hard copy or electronically, my diagnosis and other medical information to the third parties identified to determine benefits payable; also to release copies of any other medical reports we procure from other sources, regarding my current injury. Upon release to the third party listed below, AMM is not responsible for the use or release of this information pursuant to this authorization. This authorization may be revoked by you at any time by submitting a request in writing to your treating office.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment to AMM and Affiliates of any insurance, personal injury, or other benefits otherwise payable to the patient or me.

GUARANTEE OF PAYMENT: I agree to pay AMM and Affiliates for any services rendered. I acknowledge that, if AMM and Affiliates allow me to delay payment in anticipation of third-party reimbursement, including any funds procured from a settlement, such forbearance is a courtesy only, and such courtesy may be withdrawn at any time upon notice to me. **I grant AMM and Affiliates a power of attorney to collect these sums on my behalf**. If AMM and Affiliates do not offer me a delayed payment courtesy, then I understand that payment by me for services rendered are payable in full at the time of service. If a delayed payment courtesy is offered to me, but subsequently withdrawn, then I understand that payment by me for all services rendered will become due upon demand by AMM or Affiliates. I further acknowledge my responsibility for any health insurance deductible, coinsurance, or other sum not paid by an insurance carrier or any other third-party for any reason, payable upon demand by AMM or Affiliates. I understand that AMM and Affiliates may discontinue my treatment if timely payment of any sum owed by me is not made when requested. I acknowledge that a late fee of one-half percent (.5%) per month may be charged to unpaid balances remaining after thirty (30) days from the date payment is due. In the event that the account is referred to collections, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance.

PHYSICIAN CHARGES: I understand that in addition to any bills I may receive pertaining to facility (HCASC) charges; I may also receive bills on behalf of the physicians who participate in my care. These physician charges are not included in the bill from HCASC.

PERSONAL VALUABLES: Patients are encouraged to leave all money and valuables at home. AMM and Affiliates shall not be responsible for the loss of or damage to any personal property brought into AMM and Affiliates inclusive of glasses, dentures and jewelry.

TELEPHONE MESSAGES: By signing this document, I give permission to AMM and Affiliates to leave messages regarding my appointments on my answering machine or with a responsible person answering my home phone.

SUPPLEMENTAL INCOME INSURANCE FORMS: I understand and have received a copy of AMM and Affiliates supplemental income insurance form policy.

PATIENT RIGHTS AND RESPONSIBILITIES/ NOTICE OF PRIVACY PRACTICES: My initials acknowledge that I am in receipt of AMM and Affiliates Patient Rights and Responsibilities and Notice of Privacy Practices. ________________

I CERTIFY THAT 1.) I UNDERSTAND THE CONTENTS OF THIS FORM AND 2.) ALL INFORMATION GIVEN TO AMM and AFFILIATES, INCLUSIVE OF INSURANCE INFORMATION IS ACCURATE AND CORRECT. A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

Please Print Clearly in Black Ink

______________________________ Signature (Seal)**	______________________________ Date
______________________________ Patient Name (Please Print)	______________________________ Witness
______________________________ Authorized Person's Signature	______________________________ Relationship to Patient

Reason patient unable to sign (check one) ☐ Minor ☐ Condition

**Signed under SEAL is a "specialty", which requires a cause of action to be filed within twelve years after the cause of action accrues.