

CONSENT AND CONDITIONS OF SERVICE

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreements are made on my own behalf, or on behalf of the Patient in partial consideration of the health care services to be provided to the Patient by **Steven Kern, M.D.**; to provide health care services to Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. It is understood that this consent may be revoked in writing at any time. It is understood that there is risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from some such services. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that physicians are separately responsible to explain what they do.

Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all health care services rendered to Patient from **Steven M. Kern, M.D.** including, but not limited to, any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, and /or non-covered services regardless of amount paid by insurance or third party payor. It is the policy of **Steven M. Kern, M.D.** to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. In the event that payment in full for charges incurred was not made, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay all cost of collection including a 50% collection fee, all attorney fees, all court costs, and interest at the rate of 1.5% per month (18% per year). Further, the Patient or the undersigned, if other than the patient, each jointly and severally agree to pay a \$20.00 billing fee for any co-payments not paid for at the time of service and to pay a service charge of \$20.00 plus any bank charges in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to **Steven M. Kern, M.D.** In addition, it is the policy of **Steven M. Kern, M.D.**, to assess a fee for missed appointments.

THE PATIENT AND THE UNDERSIGNED, IF OTHER THAN THE PATIENT, AGREES TO PAY \$25.00 FOR A MISSED (NO-SHOW) APPOINTMENT IF THE OFFICE OF STEVEN M. KERN, M.D., IS NOT NOTIFIED WITHIN 24 HOURS OF THE APPOINTMENT DATE. _____(initial)

_____(initial) **I have read the above and accept financial responsibility, in full, for this account.**

_____(initial) **I have read and understand this document and intend that it be legally binding.**

Can we leave medical information or test results on your answering machine or voicemail? [] Yes [] No.

Can we discuss medical information or test results with family members? [] Yes [] No If yes, please indicate their names and relationship to you.

Name _____ Relationship _____

ACKNOWLEDGMENT OF REVIEW/RECEIPT OF PRIVACY PRACTICES

I, the undersigned, acknowledge that I have been given the opportunity to read the Privacy Practices. I understand that **Steven Kern, M.D.** takes every precaution to safeguard my "*Protected Health Information*" (PHI). By signing this acknowledgment I am Consenting to **Steven Kern, M.D.'s** use and disclosure of my *PHI* to carry out treatments, payment, and health care operations. If I do not sign this consent, or later revoke it, **Steven Kern, M.D.** may decline to provide treatment to myself, or to the Patient, if acting as the legally authorized representative of the Patient.

Signature of Patient or Legally Authorized Representative

_____/_____/_____
Date