

**CONSENT FOR MEDICAL SERVICES & TREATMENT**  
I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of First Physicians Group and his/her designee(s).  
**SPECIFIC CONSENT TO PELVIC EXAMINATION.** I specifically consent to a Pelvic Examination by any Provider when medically necessary and appropriate or for medical training purposes. A Pelvic Examination is a series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, a provider's gloved hand or instrumentation. As it relates to a Pelvic Examination, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended by my individual Provider.

**FINANCIAL AGREEMENT**  
The undersigned individually obligates him/her and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carriers or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition, such balance may be turned over for collection activity, at which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that First Physicians Group has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

**ASSIGNMENT OF BENEFITS**  
In the event that I am entitled to physician benefits of any and all types, I assign such benefits to SMH Physician Services, Inc. for services rendered to me. I authorize payment directly to First Physicians Group of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance, or any governmental programs such as Medicare, Medicaid, or Worker's Compensation and authorizes First Physicians Group to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

**EVALUATION OF SERVICES AND FOLLOW-UP**  
I acknowledge and agree that First Physicians Group, or any of its affiliates, may contact me by telephone or by text message to any telephone number I provide to you, or at any other telephone number associated with my account, including wireless telephone numbers, which I understand could result in charges. I further agree that you may use any method of contact to any of these telephone numbers, including prerecorded or artificial voice messages, text messages and automatic dialing devices.  
  
You may also contact me via electronic mail using any email address I have provided to you for use. I acknowledge the contact information provided to you is private to me and I take sole responsibility for maintaining the privacy of any of the information I provide to you. I further understand that in order to revoke my consent to be contacted, I must send a written revocation of my consent to First Physicians Group or to the affiliate contacting me on behalf of First Physicians Group.  
  
I give permission for First Physician Group and/or its agent(s) to contact me for the purpose of evaluating the services rendered to me.  Yes  No  
  
The undersigned certifies that he/she has read and **understands all of** the above, fully accepts all specified terms therein, and **has received the information on patient rights, including the mechanism for initiation, review, and resolution of complaints and has been offered a copy of the revised 02/01/2026 SMHCS Notice of Privacy Practice.**  
  
 **I have declined a personal copy of the revised SMHCS Notice of Privacy.** I further understand that the SMHXchange is a Health Information Exchange (HIE) that grants providers involved in my healthcare access to my most recent visits. I can change my authorization for SMHXchange at any time by calling (941) 917-6622.

**LIFETIME MEDICARE B & MEDIGAP SIGNATURE AUTHORIZATION**  
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in First Physicians Group including physician services. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services or its agents any information needed to determine these benefits or benefits for related services.

\_\_\_\_\_  
Name of Beneficiary  
\_\_\_\_\_  
HIC Number

**LIFETIME MEDIGAP SIGNATURE AUTHORIZATION**  
I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to First Physicians Group for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to any information needed to determine these benefits payable for related services.

\_\_\_\_\_  
Name of Medigap Insurer  
\_\_\_\_\_  
Name of Beneficiary  
\_\_\_\_\_  
Medigap Policy Number

**NOTICE OF PRIVACY PRACTICES**  
I have been offered a copy of the revised SMHCS Notice of Privacy Practices that describes how First Physicians Group may use and disclose my health information, and also describes my rights regarding my health information.

**INSURANCE PRECERTIFICATION**  
I understand that, **before service is rendered**, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance. I understand that First Physicians Group may assist me with obtaining authorization and/or referral for services from time to time by either contacting my insurance company directly or hiring an outside company.

\_\_\_\_\_  
*Print* Name of Patient or Legally Authorized Representative      Date  
/ /

\_\_\_\_\_  
*Print* Name of Guarantor of Payment      Date  
/ /

\_\_\_\_\_  
*Print* Name of Witness      Date

\_\_\_\_\_  
*Signature* of Patient or Legally Authorized Representative

\_\_\_\_\_  
*Signature* of Guarantor of Payment  
(state relationship if other than patient)

\_\_\_\_\_  
*Signature* of Witness