MEDICE PRIMARY CARE

GENERAL CONSENT FORM

Patient Name: _____ **DOB:** _____/_____/_____

Assignment of Benefits
I authorize Medice Primary Care, ("MPC") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that MPC will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.
Patient Initials: _____

Consent for Treatment
I consent for MPC to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, MPC may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at MPC's expense.
Patient Initials: _____

Authorization to Leave Recorded Messages
I authorize MPC and all third party providers and practitioners who provide health care services to me, along with their billing and collection agents, to contact me on my cell phone and/or home phone, including through the use of pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication for the purposes of payment for services or for health care related notices.
Patient Initials: _____

Acknowledgement of Receipt of Office and Financial Policy
In consideration of the services to be rendered to the patient, the patient and/or other legally responsible person signing this document assumes full financial responsibility for the payment of the patient's account. If the account is referred to an attorney or collection agency, the same person authorizes credit investigation and agrees to pay actual attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.
Patient Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices
I acknowledge the receipt of MPC's Notice of Privacy Practices.
Patient Initials: _____

Print Name of Patient/Parent/Guardian _____

Signature of Patient/Parent/Guardian: _____ Date: _____