Hardee Family Medicine

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CONSENT FORM FOR _____

CONSENT FOR MEDICAL TREATMENT

I acknowledge that I am suffering from a condition requiring medical care and thereby voluntarily consent to such medical care including diagnostic procedures and medical treatment by my physician, assistants or designees, as may be necessary in his or her judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I have read this consent and voluntarily certify that I understand and agree to its content.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGN INSURANCE BENEFIT'S

Hardee Family Medicine and its physicians are authorized to release any medical information required in the processing of applications for financial coverage including information referring to psychiatric care, drug and/or alcohol abuse, sexual assault and/or results of tests for all infectious diseases. I permit a copy of this authorization to be used in place of the original. I certify that the information given by me in applying for payment is correct. I authorize benefits be made in my behalf.

I guarantee payment of all charges on this patient/guarantor account and assign to the physicians any and all benefits relating to this patient/guarantor account whether insured or self-funded. I further assign the proceeds of all claims, resulting from or relating to the financial liability of this account made by a third party: any person, employer or insurance company on behalf of this account, unless the account is paid in full upon discharge. If eligible for Medicare, I request Medicare services and benefits. I understand I am responsible for any charges not covered by insurance or other form of health benefit.

PERSONAL LIABILITY

I understand that I am personally responsible for the charges resulting from care and treatment. Any payment received by Hardee Family Medicine as a result of the above Authorization for Release of Medical Information and Assignment of Insurance Benefits will be credited toward my patient/guarantor account and I will be personally liable for any and all remaining balances on the account.

I further understand that if the third party payor denies benefits or fails to make payment within 30 days of submission, I will be personally responsible for the entire balance on the account.

_____

Signature of Patient (Parent or Legal Guardian in case of a Minor) Date

_____

Signature of Guarantor (if different from patient) Date

_____

Signature of Witness Date