



General Consent & Acknowledgement Form

Patient Name:

DOB:

Consent for Treatment

I consent to evaluation and treatment of the condition for which I, or my child or dependent, have come to **Florida Health Care Medical Group (FHCMG)** and authorize the physicians and other health care providers affiliated with CPC to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by FHCMG. I authorize FHCMG to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at FHCMG.

Responsibility for Payment / Assignment of Benefits / Contact In consideration of the treatment provided at CPC to me or my child or dependent,

I agree to pay FHCMG for such treatment. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover the treatment, I authorize FHCMG to bill any such insurer for all charges incurred in connection with the diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided.
- I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying **FHCMG** for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.
- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified, I will be responsible to pay all list charges for the treatment and services received.

I hereby assign to **FHCMG** and the professionals involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such services to be made directly to **FHCMG**.

I further agree to pay all cost of collections, including reasonable attorney's fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of Florida.

I agree that in order for **FHCMG** to service my account or to collect any amounts I may owe, **FHCMG** or a vendor acting on its behalf, may contact me by telephone at any telephone number associated with my account, including cellular telephone numbers, which could result in charges to me.

I agree that **FHCMG** or a vendor acting on its behalf may also contact me by sending text messages or e-mails, using any e-mail address I have provided. I acknowledge and agree that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Further information concerning **FHCMG** financial practices and expectations can be found in the Patient Billing Notice, which has been offered to me.

Patient Rights and Responsibilities I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my health history and presenting complaint, to **Florida Health Care Medical Group**

General Consent & Acknowledgement Form agree upon a treatment plan, and follow that plan. I understand that my health care providers will treat me with respect, and I agree to do the same for them. Use and Disclosure of Health Information I understand that **FHCMG** will use and disclose my health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

I understand and acknowledge that **FHCMG** may record medical and other information related to my treatment in paper, electronic, photographic, video and other formats and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. I give **FHCMG**, its employees and agents consent to exchange information with other health care professionals and providers (for example physicians, consultants, hospitals, nursing homes, home health agencies and pharmacies) about my prior and current health conditions to facilitate treatment, or to facilitate discharge planning.

As applicable, I specifically consent to the release by **FHCMG** of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to:

1) my treating physicians and independent professionals and other healthcare professionals and providers, and;

2) Any private health insurance plan, Medicare, Medicaid, other governmental insurance program or other third-party payor that I identify to obtain payment for the treatment and services provided to me.

Communication Preferences

I agree that **FHCMG** may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any telephone number I have provided, and may communicate with me electronically to any email address I have provided. My preferred method of communication is (check one):

- Cellular phone**
- Home phone**
- Work phone**

Medical information and test results may be left on my answering machine/voice mail (check one): Yes No

Medical information and test results may be sent to me via text message to my cellular phone (check one): Yes No

Would like medical information and test results faxed to me at my personal fax number (check one): Yes No

If yes, please provide your personal fax number _____. I agree to allow

FHCMG to contact the following family or friends as necessary to provide appointment reminders, to obtain payment and to receive information of my location and general condition. I understand that **FHCMG** may contact these identified individuals for these purposes unless I later instruct **FHCMG** otherwise (check one):

- Yes No

If yes, please provide the following – Name, Address, Phone number, Relationship

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free and voluntary act.

Patient or Authorized Person Signature _____

Relationship to patient _____

Printed Name: _____

Date ____/____/____