

CONSENT TO TREATMENT AND AUTHORIZATIONS

PATIENT ID #

PATIENT NAME

AGE

DOB

TODAY'S DATE

CONSENT TO TREATMENT: The patient and/ or authorized representative of the patient, whose signature affixed below, does hereby consent to any and all medical treatments and diagnostic examinations administered at or offered in association with the operation of the GME CLINICS which treatments/examinations may be deemed advisable by my/the patient's physician to diagnose and/or treat me/the patient during the period I/the patient am accepted as a patient of the GME CLINICS.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: I hereby authorize the GME CLINICS and each of my physician(s) to release medical, psychiatric and substance abuse information, whether contained now or in the future, in my/the patient's records to the following: insurance carrier(s) and/or employer(s) and/or organization(s) or, corporation(s) for the limited purpose of obtaining payment of all or part of the GME CLINICS' charge for medical care rendered, including professional fees of physicians practicing at the Clinics, which may include financial and medical record information to substantiate the need for the medical care rendered and the cost associated with medical charges incurred.

The federal HIPAA Privacy Regulations authorize health care providers to share your medical information for treatment purposes, without your consent, including treatment received after you leave the hospital. Florida law, however, restricts (in some instances) the ability of the hospital to share your medical information with health care providers for treatment purposes, if treatment is sought after your discharge. By signing this consent, you authorize the release of your hospital records (current and historical) to health care providers with whom you or your treating physician(s) may consult for medical treatment. If you do not want to consent, you must cross through this paragraph and please initial in the margin next to the paragraph.

This consent will remain in force during the period that I/the patient is accepted as a patient of this Clinic. You may revoke this authorization at any time by notifying the Clinic in writing, however, your revocation will not affect any action taken by the Clinic prior to receipt of notice of your revocation and the Clinic has a reasonable opportunity to act upon the revocation.

Information disclosed pursuant to your authorization is from records whose confidentiality is protected by Federal and State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse information without specific written consent of the person to whom it pertains, or as otherwise permitted by Federal/State law. The Faculty monitors the residents' management of the patients by regularly reviewing the charts, discussing the visits, photographing educational cases and occasionally video monitoring some visits. (Requires separate consent for video taping.)

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment directly to the GME CLINICS all insurance benefits otherwise payable to me for medical treatment rendered by the Clinics. I understand I am financially responsible for charges not paid by this assignment, and that I/the patient will assist in the collection of my/the patient's insurance should there be any delay in payment. **If my/the patient's insurance payment has not been received by the GME CLINICS within 30 days of billing, I/the patient agrees to actively and vigorously pursue collecting the insurance payment. If my/the patient's insurance has not remitted charges due with 45 days of receipt of treatment, I understand the entire balance becomes due and that the GME CLINICS may seek payment direct from me/the patient. THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.** Returned checks are subject to electronic redeposit without further notice. State authorized returned check fees will be assessed and will be debited from your checking account without further notice, along with the face amount of the returned check.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made on my/the patient's behalf to the GME CLINICS. I authorize any holder of medical information about me/the patient to release to the Health Care Financing Administration and its agents, any release of medical information needed to determine benefits payable for released services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge authorized by the Medicare carrier.

INSURANCE RECORD OF UNDERSTANDING: Your insurance company may require pre-authorization, usually through your physician, to determine for which service(s) they will pay. Your insurance company may not pay your claim or may reduce benefits if you do not provide us with a proper authorization. After the pre-authorization is obtained, additional information may be required by your insurance company for each visit to be covered. I understand that if I do not obtain the proper authorization, I will personally be liable to pay any penalty up to the total amount charged for the services received.

PATIENT/GUARANTOR AGREEMENT: I/we understand that the GME CLINICS are not in the business of extending credit, and therefore, the policy of the CLINICS is to require **PAYMENT IN FULL AT THE TIME TREATMENT IS RENDERED.** If the GME CLINICS must use services of a collection agency or a service to encourage prompt payment, a collection charge may be imposed. We may also choose to provide you with notice that you are being discharged as a patient of our Clinics.

NOTICE TO GUARANTOR: Do not sign the contract before you read it or if it contains blank spaces. You are entitled to an exact copy of the agreement you sign. The undersigned hereby acknowledges receipt of a copy of the above disclosure statement containing all information pertinent to this transaction. By signing the patient/ guarantor agreement, the guarantor(s) agree(s) to guarantee payment of all charges incurred by the patient for services at any Clinic operated by or in association with GRADUATE MEDICAL EDUCATION CLINICS including medical care rendered by any Florida Hospital facility. This is an absolute guarantee and it shall continue as long as any balance is due and owing for medical care rendered by a Clinic/Florida Hospital facility to the patient.

I understand I am financially responsible for my account with Florida Hospital (INCLUDING GME CLINICS), regardless of any insurance benefits. (By my signature below, I acknowledge reviewing the information contained in this document.)

Patient Signature

Staff Witness

Date

Spouse, Next of Kin, Parent, Guardian, or Other Representative Staff Witness

Date

By signing this form, I acknowledge that I have received the HIPAA Notice of Patient Privacy Practices document at the GME CLINICS.

Patient Signature

Date

Staff Witness

Date

Patient Name: _____

Patient #: _____

Patient Address: _____

Date of Birth: _____

Street

Apt. #

City State Zip Code

SSN #: _____

Patient Phone Number: _____

Today's Date: _____

I hereby request Medical Education Clinic to (please check all boxes that apply):

- Provide me with access to the Protected Health Information (PHI) specified below
- Provide me with copies of the Protected Health Information (PHI) specified below

The purpose of this request:

- At my request
- Other (describe) _____

The description of the specific protected health information to be accessed:

- My medical records for dates of service: _____
 - Medical Record
 - most recent
 - 3 months
 - 6 months
 - Consultation
 - History and Physical
 - Laboratory Report(s)
- My billing Record(s) for date(s) of service: _____
 - Radiology Report(s)
 - Pathology Report(s)
 - Operative Report(s)
 - Other (specify) _____

I authorize _____

to disclose the protected health information specified above to:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ FAX Number: _____

I have read and understand the following statements:

I understand that if I request a copy of the protected health information specified herein Medical Education Clinic may impose a reasonable, cost-based fee for such access.

I understand that if I am denied access to all or a portion of my protected health information, the protected health information that I have been denied access to may not be disclosed as authorized in this form.

I understand that this form is revocable, upon written notice to Medical Education Clinic but if I do, it will not have any effect on any actions Medical Education Clinic took before if received the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify an expiration date, event, or condition, this authorization will expire ninety (90) days from the date signed.

I understand that signing this form is completely voluntary and I am signing it under my own free will. I understand that Medical Education Clinic will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

I understand I will receive a signed copy of this Form.

If this form authorized the use/or disclosure of psychotherapy notes, it may not be used to authorized the use and/or disclosure of any other protected health information.

- I AM THE PATIENT AND I UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FORM/AUTHORIZATION.**
- I UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FORM ON BEHALF OF THE INDIVIDUAL INDICATED BELOW TO BE THE PATIENT. I HAVE SIGNED MY NAME INDIVIDUALLY AND IN MY CAPACITY AS THE LEGAL REPRESENTATIVE OF THE PATIENT AND I HAVE ATTACHED A COPY OF THE COURT ORDER DESIGNATING ME AS THE GUARDIAN OF THE PATIENT, OR DOCUMENTATION DESIGNATING ME AS THE LEGAL REPRESENTATIVE FOR THE PATIENT.**

Printed Name of Patient

Patient's Signature

Printed Name of Legal Representative

Legal Representative's Signature

Printed Name of Witness

Witness' Signature

Date & Time