CONSENT FOR CARE AND TREATMENT

I, the undersigned do hereby agree and give my consent for **Tarpon, PA** to furnish medical care and treatment to____________________ _______________ considered necessary and proper in diagnosing or treating his/her physical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to **Tarpon, PA**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

I understand that all copays, deductibles, and/or services that are not covered by my insurance company are my responsibility. I understand that payment plans are available I agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies paid, including court costs, collection agency fees, and attorney fees.

PATIENT PRIVACY PRACTICES

I have read and understand the Patient Privacy Practices provided to me by **Tarpon, PA.** I understand that my personal health information will be used in treatment, payment and operations; including those activities which are performed in order to improve the quality of care. I acknowledge my receipt of this information.

I give authorization for the release of "Medical Records/Privacy Information" to the following:

____________________________________ ____________________________________
Name Relationship to Patient

____________________________________ ____________________________________
Name Relationship to Patient

I wish to be contacted in the following manner (check all that apply):

_ Home Telephone ______________________________

_ O.K. to leave message with detailed information

_ Leave a message with call-back number only

_Work Telephone ________________________________

_ O.K. to leave message with detailed information

_ Leave a message with call-back number only

_ Written Communication

_ O.K. to mail to my home address

_ O.K. to mail to my work/office address

_ O.K. to fax to this number _____________

_ Other ___________________________________

____

____
Print Patient's Name Here

____ ______________________
Patient/Guardian/Responsible Party **Date**

____ ______________________
Clinic Representative/Witness **Date**

Tarpon, PA 5425 W. Spring Creek Parkway, Suite 100 Plano, Texas 75024