Patients Full Name: _____

Date of Birth: _____

GENERAL CONSENT FOR OUTPATIENT DAIGNOSTIC, CARE AND TREATMENT

On an ongoing basis, I request, consent and authorize HealthFirst Family Care Center to perform diagnostic and therapeutic tests, procedures and provide general care and treatment as determined necessary and/or ordered by those health care professionals involved in my care. This includes, yet not limited to, the performance of physical examinations, taking blood, fluids or other bodily samples.
Be advised that laboratory services provided by HealthFirst may be processed by an outside laboratory. If your health insurance requires you to utilize a participating or in-network laboratory please inform the nurse prior to receiving lab services. You will be billed separately by the Laboratory and should be aware of your insurance coverage for these services.

BEHAVIORAL HEALTH SERVICES

HealthFirst Family Care Center provides an integrated team approach for the coordination of primary and behavioral health care. As an integrated team all staff members work together, improving communication among providers by sharing information in one medical record and decision making, as well as shared responsibility for patient's care plan. Behavioral Health Services are available to all individuals. I consent to the sharing of my Private Health Information (PHI) in order to formulate a plan of care. I understand health care professionals in training may be involved in my care and I consent to their involvement in it under appropriate supervision.

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNEMENT OF BENEFITS

I understand that I am financially responsible for all of the charges associated with the services I receive at HealthFirst Family Care Center. I understand that my Protected Health Information (PHI) may be used in connection with billing statements sent to me and in connection with checking for eligibility for health insurance coverage and preparing claims for my insurance company where appropriate.

I, _____ (Patients first and last name) authorize HealthFirst Family Care Center to release/disclose any and all information pertinent to the authorization of my services by my insurance company and pertinent to the billing for services I receive to

_____ (Insurance Carrier/Third party payer). I authorize my health insurance or third party payer to make direct payments to HealthFirst Family Care Center for services provided. This information may include the following substance I acknowledge that I am responsible for any co-payments, deductibles, or charges not covered by my health insurance.

MEDICARE ONLY

I request payment of authorized Medicare benefits be made either to me or on my behalf to HealthFirst Family Care Center for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the HealthFirst financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. (This payment authorization is valid for any service provided to beneficiary during his/her lifetime, unless revoked.)

_____ If you have Medicare please initial to confirm you have read and understand this section.

AUTHORIZATION TO DISCLOSE MEDICATION HISTORY

I authorize HealthFirst Family Care Center to request and use my prescription history from other healthcare providers or third-party pharmacy or benefit payers for treatment purposes.
Any questions I had about this consent have been answered. I understand the information in this form and agree to the conditions set forth above.

_____
Patient/ Parent/ Guardian Signature

_____
Today's Date
(Must be 18 years or older)