Date: ____/____/_____

Patient Name: _____

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to My House Clinic (MHC) and consent to treatment by the physician/nurse practitioner on duty and whomever they designate as their assistant, associate, treating physician and client care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, examinations and the administration of medications considered advisable in my diagnosis, treatment and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks. I acknowledge consent to allow MHC to search all available electronic drug databases for any current or past medications.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to MHC any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by MHC to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are otherwise made with MHC and its respective billing service. I acknowledge that my visit with MHC constitutes a credit and financial transaction.

GOVERNMENT COMPLIANCE

In compliance with the enacted Patient Protection and Affordable Care Act and the Stark Law, MHC must inform you that there are other options for laboratory, diagnostic and radiographic services. Specifically, it should be noted that you have presented to MHC voluntarily for your medical needs and that as part of the evaluation of your medical condition and any required treatment, the provider on duty may determine that certain laboratory, diagnostic and radiographic tests may be needed. MHC offers many of these services on-site as a convenience to our clients. If the client would like to have these services provided at another facility, MHC will provide you with a list of nearby locations.

RELEASE AND USE OF CLIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice and specific health information to:

1. TREATING PHYSICIANS on staff at MHC and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to any other referred medical consultants for follow-up care.
2. INSURANCE COMPANIES or other third-party payers and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided and ensuring government compliance.

I understand that this information may contain my personal medical history, physicals, treatments and laboratory results, and more specifically results about human immune-deficiency virus, (HIV/AIDS) hepatitis, other infectious diseases and mental health.

***I understand that I have the right to revoke this authorization at any time.**

Signature of Client or Parent/Guardian: _____ Date: _____/_____/_____