FIU HEALTH
FACULTY GROUP PRACTICE
General Consent to Treatment and Financial Responsibility

Acknowledgement of Receipt of Notice of Privacy Practices

I _____, hereby acknowledge receipt of Academic Health Center and Florida International Faculty Group Practice, Herbert Wertheim College of Medicine Green Family Foundation Neighborhood Help Program (the "Notice") on _____ (date). Please sign below indicating receipt of the Notice.

Name: _____ Signature: _____ Date:_____

Consent for Medical Treatment

The undersigned hereby consent to any and all diagnostic procedures, tests, and medical treatment required in the diagnosis of my illness and course of treatment by the physician or his/her designee; other agents, and/or employees of the Florida International University, including residents and medical students. I recognize that the Florida International University Herbert Wertheim College of Medicine is a teaching and research facility and that my treatment and care may be observed and in some instances aided by medical students in their course of training. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of tests, examinations, treatments, procedures or any other services rendered.

Release of Medical Information (Third Party Payors, Guarantors, Physicians)

By signing this form, I hereby authorize this institution to use and release information and/or copies of my medical records as necessary for my treatment, for payment for that treatment and for the health care operations of the providers treating me; including to a hospital, physician or other provider, guarantor, of my accounts, or third party payors for which I have assigned benefits for my treatment and care, and, if requested, to my referring physician, or any other healthcare provider responsible for my care; and as otherwise provided in the Florida International University Notice of Privacy Practices. This includes information pertaining to psychiatric and/or psychological care, alcohol and/or substance abuse, AIDS, ARC, or HIV diagnosis, testing and/or treatment for this period of illness. It also includes other admissions if related to the accident or illness giving rise to this episode of care, and other information as necessary for the operations of the faculty practice or as required to secure payment for charges incurred by me or on my behalf, including a diagnosis of my medical condition. I further authorize the Department of Health and Human Services and/or Social Security Administration to release any confidential case information related to my application for government assistance requested by the Florida International University Herbert Wertheim College of Medicine.

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Florida International University. I understand that Florida International University will bill my insurance; however, I understand that I am responsible for any charges not covered by my insurance company as allowed by law.

Patient Name: _____

DOB: _____

Assignment of Benefits

I hereby assign with my signature below, to Florida International University any insurance or other third-party benefits available for health care services provided to me. I understand that the Florida International University has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the Florida International University, I agree to forward the Florida International University all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I acknowledge that I have read and understand the information provided herein. I have also had the opportunity to ask questions and by my signature, I consent and agree to the above.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein.

If other than the patient signing, I _____am the legal guardian, custodian or have Power of Attorney for this patient, for purpose of treatment, payment or health care operations

Signature of Patient or Guardian:_____

Printed Name of Signer:_____

Relationship to Patient:_____