_____

Patient Name (Please Print)

CONSENT TO CLINIC AND MEDICAL TREATMENT

MEDICAL CONSENT: I, knowing that I, have a condition requiring clinic or medical care, do hereby voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by my physician, his/her designees, including clinic personnel, as is determined necessary in his/her judgment. 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 results of treatments or examination in the Coddington Medical Family Practice, LLC. This consent is designated to cover all procedures in the clinic which do not require a specific consent form.

NARCOTICS, DRUGS OR MEDICINES: My use of any narcotics, drugs or medicines will be subject to clinic control, and I agree that all such narcotics, drugs or medicines will be kept in the clinic's possession to be dispensed in accordance with the clinic's rules or regulations.

PRESERVATION OF TISSUE: I hereby authorize Coddington Medical Family Practice, LLC to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during my clinic procedure.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize Coddington Medical Family Practice, LLC to furnish to the insurance carrier(s) or their agents identified on the factsheet attached to this form such information as it or they might need to request concerning my present treatment in the clinic. I also authorize Coddington Medical Family Practice, LLC to provide my insurance carrier verbal/written communication, reports or other data prepared by the Utilization Review Committee personnel concerning my present treatment. I further authorize Coddington Medical Family Practice, LLC to advise my insurance carrier(s) if and when it is determined by the Utilization Review Committee that I no longer require acute care. I agree to the transfer of medical information to the health care provider(s) or facility that will provide continuation of my health care. A photocopy of this authorization shall be considered as valid as the original.

ASSIGNMENT OF BENEFITS: I hereby authorize and assign payment directly to the Coddington Medical Family Practice, LLC clinic any insurance benefits relative to this service. I also understand I am responsible for any amount not covered or paid by my insurance benefits authorized by this assignment.

CONFIDENTIALITY: I understand that the clinic will endeavor to protect the confidentiality of my medical records, however, the clinic shall not be liable by reason of said records or any part thereof when responding in good faith to an apparent valid request. I also understand that I may review and copy my medical records at my own expense and that this review shall take place in the Medical Records Department during regular business hours.

*****PLEASE COMPLETE FOLLOWING QUESTIONS <u>ONLY</u> IF YOU HAVE <u>MEDICARE</u>*****

Yes	No	
__	__	1) Are you entitled to Black Lung Benefits or VA service card?
__	__	2) Is your visit due to an accident? If so, did the accident happen ___ at work, ____at home,____auto
__	__	3) Are you covered under group health insurance?
__	__	4) Are you employed? If not, retirement date: _____
__	__	5) Is your spouse employed? If not, retirement date: _____
		6) Please check reason you are eligible for Medicare: ____ age 65 or over, ____disabled, ____end stage renal disease

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THIS FORM HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

_____ _____

Date Patient's Signature

If the patient is unable to consent or is a minor, please complete the following:

_____

State reason patient is unable to consent

_____ _____

Signature of Parent, Legal Guardian, Authorized Representative Relationship to Patient

_____

Witness

Coddington Medical Family Practice, LLC