I authorize direct payment of medical benefits and/or private insurance benefits on my behalf for any services furnished to me by Coddington Medical Family Practice, LLC to be submitted directly to their office. I authorize the release of any medical information necessary to coordinate care with other physicians and to process claims. **I understand that I am financially responsible for all charges whether or not paid by my insurance company.** This may include but is not limited to outside lab testing and/or radiology services. It is necessary for our patients to take responsibility for checking with their insurance company for specific plan benefits and/or eligibility.

I hereby authorize Coddington Medical Family Practice, LLC providers or staff to leave information regarding my Protected Health Information (PHI) or my Treatment, Payment, or Operation Information (TPO) on my answering machine or voicemail. (Circle One) **Yes** or **No**.

I have been given information to read and review about the Health Insurance Portability and Accountability Act (HIPAA) which notifies me about protecting the privacy of my health information.

I have read this information thoroughly and understand it.

Patient Signature:_____ **Date:**_____

(Parent, Legal Guardian if minor, or Representative)

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 fact sheet 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 with 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 medical record, however, the clinic shall not be liable by reason of said records or any part thereof when responding to 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.

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

Patient Signature:_____ **Date:**_____

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

State the reason patient is unable to consent:_____

Signature of Parent, Legal Guardian, Authorized Representative:_____

Relationship to Patient:_____

Clinical Personnel Witness:_____