



CREDO

FAMILY MEDICINE

Patient Consent Form

Treatment:

- I hereby consent for Credo Family Medicine to administer health care in all forms, including care, treatment, services, examinations, tests, consultations or procedures to diagnose and treat me and my medical conditions. I voluntarily give such consent and acknowledge I may revoke this consent with a written notice at any time.
- I hereby consent for Credo Family Medicine to administer health care in all forms, including care, treatment, services, examination, tests, consultations, or procedures to diagnose and treat the minor/child _____ in my legal care as Parent/Legal Guardian. I agree that I have the legal authority to act on behalf of said minor and that said minor legally cannot sign for himself/herself.
- I hereby acknowledge that I am aware of the Mission, Values, and Ethics statements of Credo Family Medicine (as found on their website www.credofamilymedicine.com), and I consent to receiving health care from Credo Family Medicine within the stated parameters of said statements.

Financial Responsibility:

- I hereby acknowledge that I financially responsible for all services and health care administered to me from Credo Family Medicine, with such limitations as provided by my insurance company or other third-party benefits contract. I agree that I am responsible and will pay all applicable balances on my account, including co-pays, deductibles and co-insurance amounts. I also agree that I am financially responsible for any services not covered by my insurance or for which my benefits have been exhausted, any out-of-network benefits, and for any services denied coverage through lack of prior authorization on my part. I agree that I will pay my balances with Credo Family Medicine by the dates specified on my account. I acknowledge that if I fail to pay said balances, I may be sent to collections and will be responsible for all collection fees incurred.
- I hereby assign Credo Family Medicine with the ability to access my rights to be reimbursed by my insurance company or other third-party benefits contract. I hereby request that all payments for my health care be made from my insurance company to Credo Family Medicine on my behalf. In the event such payments are not made to Credo Family Medicine from the insurance company, I agree to forward such payments to Credo Family Medicine. I hereby grant permission for Credo Family Medicine to transfer/transmit/receive information regarding my applicable benefits and coverage with my insurance company or third-party benefits contract.

Privacy Acknowledgement:

- I hereby consent for the providers and those involved in my medical care of Credo Family Medicine to transfer/transmit/receive my health information as may be required to any person, corporation, or agency who Credo Family Medicine has reason to believe is legally responsible for processing the payment of received health services on my behalf. I further consent that Credo Family Medicine and all providers and those persons involved in my medical care may transfer/transmit/receive my health information to such affiliated health professionals as deemed necessary by Credo Family Medicine for the purposes of fulfilling the administration of my medical care.
- _____ I hereby acknowledge that I have been offered the opportunity to review Credo Family Medicine's Notice of Privacy Practices.

Patient Name: _____

Patient Signature: _____

Parent/Legal Guardian Signature: _____

Guardian's Relationship to Patient: _____ Date: ____/____/____