

Consent Form

PATIENT NAME: _____

SOCIAL SECURITY NO. _____

DATE OF BIRTH _____

I give Creekmore Clinic, PLLC (CREEKMORE CLINIC) permission to render treatment and procedures by physicians, members of the house staff and employees of CREEKMORE CLINIC. The undersigned has read and understood this Consent Form and certifies that no guarantee or assurance has been made as to the results that may be obtained.

I understand that as part of my health care, CREEKMORE CLINIC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. a basis for planning my care and treatment
2. a means of communication among the many health professionals who contribute to my care
3. a source of information for applying my diagnosis and surgical information to my bill
4. a means by which a third-party payer can verify that services billed were actually provided
5. and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that CREEKMORE CLINIC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that CREEKMORE CLINIC has already take action in reliance thereon.

I authorize CREEKMORE CLINIC to release any information acquired in the course of examination and treatment in connection with CREEKMORE CLINIC visit for the purpose of insurance and Medicare benefit payments to CREEKMORE CLINIC and the Physician. If covered by valid medical insurance, I authorize payment directly to CREEKMORE CLINIC the benefits herein specified and otherwise payable to me, and authorize release of information for insurance purposes. I agree to pay for the services upon release of above named patient.

X

Signature of Patient or Legal Representative

Date

Print Patient's Name

Print Name of Legal Representative (if applicable)

Relationship to Patient

I request the following restrictions to the use or disclosure of my health information.

FOR OFFICE USE ONLY

Restrictions Accepted Restrictions Denied

If patient has a personal representative, enter name:

Signature

Title

Date