BOCACARE®
BOCA RATON REGIONAL HOSPITAL
PHYSICIAN NETWORK

Consent for Treatment

Patient Name: ___________________________________ **Patient DOB:** ______________________________

General Consent for Medical Treatment: I hereby authorize the above named physician or other care providers designated by him/her, providing care to the above named patient to render outpatient care encompassing diagnostic procedures, physical and mental examinations, medical treatment, routine laboratory work performed in office and medications as they may deem to be necessary or advisable in the diagnosis or treatment of this patient. I direct Boca Care, and its employees to follow his/her or their instructions and direction. I further consent Boca Care to conduct venereal disease or blood born pathogenic testing (including but not limited) to testing for hepatitis, Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV), if ordered by **protocol**. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collections of blood specimens including discomfort from the needle stick and/or slight burning, bleeding, or soreness at the puncture site. The results of this test will become part of my confidential medical record. I understand that if I test positive, my test results will be disclosed to the Florida Department of health with information identifying.

Guarantee of Payment: In consideration for the services to be provided to the patient, each of the undersigned promise(s) to pay BocaCare during the course of services rendered. All amounts legally due and not paid by Medicare, a third party payor, or other source on my behalf for said services rendered, which payment shall be due at any time, unless it is contractually stated that I will not receive a bill. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney's fees. I authorize BocaCare and its business associates, to contact me by the use of any automatic dialing system, pre-recorded forms, voice messaging systems or contact me via the telephone numbers provided by the undersigned.

Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance. I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me.

Acknowledgements: I understand I have the right to review BocaCare's Notice of Privacy Practices prior to signing this Consent. The Boca Care Notice of Privacy Practices will be provided to me if requested. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of BocaCare. The Notice of Privacy Practices for BocaCare also describes the rights and the duties BocaCare with respect to my protected health information. BocaCare reserves the right to change the privacy practices described in its Notice of Privacy Practices.

I hereby acknowledge that I have received, viewed, read understand and accept the terms of this consent. I agree to all care and treatment provided by BocaCare for one year from the date signed and I have the right to revoke this consent in writing, at any time. I acknowledge that BocaCare provided me with the opportunity to ask questions and that any questions were answered to my satisfaction.

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Signature of Patient/ Personal Representative Date/Time

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Print Name and Relationship patient if signed by Personal Representative

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Signature Witness

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Printed Name and Title of Witness