ASEPTIC PRIMARY & FAMILY
PRACTICE CLINIC LLC

Address: 1505 Highway 6 S STE 240 Houston TX 77077
Phone: 832-725-0271
www.asepticprimarycare.com

Authorization and Agreement for Services

Patient Name: _____

HIC#:

CONSENT TO TREAT:

I hereby authorize employees and agents, including physicians, nurse practitioners, physician assistants and nurses of **All Care Family Medicine, PLLC** to render routine medical care as they deem necessary to the patient indicated on this form. The duration of this consent is indefinite and continues until revoked in writing.

FINANCIAL RESPONSIBILITIES: I hereby authorize payment of medical benefits for services rendered to **All Care Family Medicine, PLLC**. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and request payment be made on my behalf. I further understand that although my health insurance coverage has been verified, there is no guarantee they will reimburse **All Care Family Medicine, PLLC** for services rendered, and I am financially responsible for the unpaid balance.

RELEASE OF INFORMATION: I understand that as part of the healthcare services, **All Care Family Medicine, PLLC** creates and maintains health records and other information describing, but not limited to, my health information, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I hereby authorize **All Care Family Medicine, PLLC** to release written, verbal or electronic information, when the information is required for treatment, payments, business operation, surveyors of government representatives. I understand by signing this form, I consent to the use and disclosure of protected health information.

PRIVACY NOTICE ACKNOWLEDGMENT: I have been provided a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information in accordance with the Health Insurance Portability and Accountability Act of 1996. I understand that I have the right to review the notice prior to signing this consent. I understand that **All Care Family Medicine, PLLC** reserves the right to change their Notice and Practice Act at anytime; and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restriction as to how my health information may be used.

The patient agrees to call the office to cancel an appointment scheduled, follow plan of care agreed after discussion with provider and patient has the right to refuse any treatment.

Patient or Responsible Party: _____

Signature: _____

Date:_____

Responsible Party Relationship:_____