CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Print Patient Name:_____Date: _____

Print Name of Parent / Legal Guardian / Authorized Representative_____Date: _____

I hereby authorize the release or use of my / or the patient's individually identifiable health information ("protected health information") and medical record information by CFP Physicians Group, P.L.© (the "Practice") in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one of our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your / the patient's care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your protected health information to that third party.

The Practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request, in writing, that we further restrict how your / the patient's protected health information is released or used to carry out our treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction(s); However, if we do agree, in writing, to your / the patient's requested restriction(s), such restrictions are then binding on the Practice.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided, either in electronic or written format, a copy of CFP Physician Group's Notice of Privacy Practices.

Signature of Patient (or Authorized Representative): _____

I acknowledge and agree that the Practice may disclose my / the patient's protected health information and medical record information to the following individuals: **(please initial line and write in name of individual)**

_____Spouse_____ _____ Parent _____

_____ Child _____ _____ Legal Guardian _____

_____ Other _____ _____ Power of Attorney_____

I agree that the Practice may also disclose the following types of information contained in my/the patient's medical record unless initialed below. (Please initial to EXCLUDE)

	Substance Abuse Information		HIV / AIDS Information
	Sexually Transmitted Disease Information		Mental Health Information
	Pregnancy Information if patient is under 18 years old.		Genetic Testing

I agree and consent to the Practice releasing information to me in the following alternative manners unless initialed to exclude being contacted in any of these below. (Only initial to EXCLUDE)

_____Via regular mail _____Via telephone _____Via email

_____Via home answering machine _____Via work voice mail

_____Via fax to my designated fax number which is: _____

The Practice may refuse to treat you if you / the patient's (or an authorized representative), do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

Print Patient Name: _____

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Date:_____ Time:_____AM / PM

_____

Signature of Patient (or Authorized Representative)

_____

Please Print Name

FINANCIAL POLICY

Payment for co-payments, deductibles and coinsurance are expected at the time services are rendered. Any necessary financial arrangements are to be made prior to treatment. We bill only insurances we are contracted with and the patient is expected to know what coverage they have. I understand and agree to comply with CFP Physicians Group©, P.L.'s financial policy.

_____

Signature of Patient (or Authorized Representative)

ASSIGNMENT OF INSURANCE BENEFITS

I authorize the release of any medical or other information necessary to process my / the patient's claims. I assign payment directly to the physicians, the benefits which may be due to me from the Medicare program or any other insurance products including supplemental insurance, which may cover in whole or in part medical services which I / the patient have received and I will assist in the collection of my insurance should there be any delay in payment. If my / the patient's insurance payment has not been received by the physician within 30 days of billing I agree to actively and vigorously pursue collecting the insurance payment for the physician. I understand that I am financially responsible to the physicians for charges that may not be covered in part or in full by my insurance company.

_____

Signature of Patient (or Authorized Representative)

ADVANCE DIRECTIVE

All adults in health care settings in the State of Florida have the right to an "advance directive". This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An advance directive enables you to state your choice or name someone to make your choice for you, should you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions.

Do you have a Living Will? _____Yes _____No
If yes, please provide the office with a copy.

_____

Signature of Patient (or Authorized Representative)

IF THE PATIENT IS A CHILD

Should my minor child ever need medical attention and I am unavailable to give my consent for treatment, this signed statement will serve as my authorization for any physician at CFP Physicians Group©, P.L. to proceed with whatever medical care the physician deems advisable until I can be reached.

_____ _____

Child's Name Parent / Legal Guardian / Authorized Representative Signature

_____

Print Name of Parent / Legal Guardian / Authorized Representative Signature