CONSENT FOR TREATMENT

Consent for Treatment

I hereby, authorize and consent to medical treatment by Dr. _____, her/his assistants or her/his designees as is necessary in her/his judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examinations.

Assignment of Benefits

I hereby authorize payment directly to _____ of all benefits otherwise payable to me, but not to exceed the total charges for the services rendered.

Authorization to Release Information

I authorize Houston Center for Infectious Diseases (HCID) to release any and all information contained in my complete medical and billing record (including patient demographics) to:

1. My primary insurance company, and secondary insurance company if applicable or its representatives.
2. Other designated persons or entities financially responsible for my care or treatment.
3. The Medicare program and their fiscal intermediaries, if applicable or otherwise required or permitted by laws, regulations, and/or Federal or state agencies, as required or permitted by law or regulations.
4. Any other Physicians, Hospitals, Surgery Centers, Imaging and Physical Therapy facilities that HCID practitioners may refer you to.
5. Day to Day healthcare operations of the practice (Communications sent to you or your designated representative via e-mail/text reminders/confirmations of appointments via online services).
6. I authorize HCID. to communicate via email, text reminders/confirmations of appointments via online services with another designated individual approved by me. If approved by you, then please provide the authorized person's information below:

   Authorized Person:_____ Phone#_____

   Authorized Person's Email Address:_____

Financial Responsibility

I understand that I am financially responsible to HCID. for all the charges for the services rendered to me. I hereby, promise to pay HCID for the services I receive.

Copies

A photo static copy of this authorization is valid as the original. It will remain in effect until I submit a written request to revoke it.

My signature indicates I have read and understand all the preceding information.

Patient/Responsible Party Name: _____

Signature: _____ Date:_____

Witness:_____Date:_____