



**SPRINGTOWN FAMILY  
HEALTH CENTER**

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**Consent to Treat Authorization Form**

1. **Consent to Treat:** The undersigned consents to any examination or medical treatment, and /or services rendered to patient by the physician/provider, which in the judgment of such practitioners are advisable during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as the results that will be attained from any diagnosis or treatment.
2. **Assignment of Benefits / Insurance Requirements:** In consideration of goods and services rendered or to be rendered. I irrevocably assign and enter all right, title and interest in all benefits / monies payable for goods and services. I understand that in the event Springtown Family Health Center files a claim on my behalf that the same does not impose and contractual obligation upon Springtown Family Health Center and that I remain responsible for instituting suit within that applicable statute of limitations. I authorize Springtown Family Health Center to appeal and denial. It is agreed that any condition, including, but not limited to, pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of patient and /or the patient' s family, legal guardian, representative or agent. I authorize the payors listed herein and any other payors to release any and all information requested and / or related to my claims(s) to Springtown Family Health Center.
3. **Financial Responsibility:** it is agreed that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges for services rendered, and I agree to pay for all charges incurred. If not a member of an Insurance HMO or PPO, fees for services provided must be paid at the time they are rendered. It is agreed that should this account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I as the designated responsible party or entity, shall pay all collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt.
4. **Release of Information/Medical Records:** I consent and authorize Springtown Family Health Center and any practitioner providing medical goods and services to patient to release information contained in any financial records and /or medical records. Including but not limited to, information concerning communicable diseases such as(HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and /or. Mail, facsimile or other electronic medium. This consent to release medical information is subject to revocation in writing at any time, except to the extent that action has been taken.
5. **Acknowledgement of Privacy Practices:** I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.
6. **Review of Office Policy:** I have reviewed the office's policy and understand the information provided within. I am aware of the *\$25 fee for late cancelations and missed appointment.*

**I THE UNDERSIGNED CERTIFY THAT I HAVE READ AND ACCEPT THIS AUTHORIZATION FORM AND THE INFORMATION THAT WAS PROVIDED.**

\_\_\_\_\_  
Name of Patient/Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date