PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

GENERAL CONSENT

Consent for Medical Treatment. I give consent to **Dixitkumar N Modi MD PA d/b/a Premier Medical Clinic**, its staff, physicians and other practitioners (the "Practice") to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial for my health and well-being.

Authorization of Payment of Insurance Benefits. I authorize payment to the Practice of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment of the service rendered to me.

Signature on File (applies to Medicare patients only). I certify that the information given by me in applying for payment under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or Center for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the Practice for services provided by the Practice.

Financial Agreement. I agree that in consideration for the services rendered to me, to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Practice. I understand that to the extent permitted by law, where insurance or other third party benefits are insufficient to pay for all of the services rendered, that I will be responsible for the payment of any balances due as determined by the respective provider of services, including deductibles, copayments, co-insurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the Practice with accurate and current information regarding my insurer at the time of service, HMO or other benefit plan/third party payor which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the Practice. I agree to pay all bills when presented. I understand that there will be a $25.00 charge for all returned checks.

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

Release of Information. I understand that the Practice will release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2)to any person or entity which may be responsible for billing/collection of claims for medical and/or occupational health services or products; (3) to any person or entity which is, or may be liable to the Practice or me for all or part of the Practice's charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any government agency or other organization responsible for oversight of the Practice or a third party payor; (5) for the Practice's normal health care operations. I understand that the Practice may communicate information including protected health information with me through text or email, and through the Practice's electronic health record system. I understand that to ensure continuity of care, all Island Family Health providers will have access to the information in my electronic health record.

I understand that the Practice may access information from any pharmacy from which I have filled prescriptions. This includes prescriptions for medicines to treat AIDS/HIV, mental health illness, substance abuse, and STDs, if applicable. I further understand that this information will become a permanent part of my medical record.

Acknowledgement of Receipt of the Privacy Notice. I have received a copy of the Practice's Privacy Notice and have had the opportunity to receive assistance in the understanding and exercising these rights.

Signature. I have carefully read and fully understand this General Consent form.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

IF SIGNED BY A LEGAL REPRESENTATIVE (PRINT NAME) DATE

_____

RELATIONSHIP TO PATIENT