Lifecare Primary Medical Associates, PLLC

633 E Fernhurst Dr. Suite 202. Katy, TX-77450, Tel: 281-712-7757, Fax: 281-712-7758

CONSENT FORM

Patient's Name: ______________________________

I give my consent to treatment as necessary or desirable for the care of the patient first named above, including but not restricted to whatever drugs, medicine and conduct of laboratory, X-ray, or other studies that may be used by the attending physician, nurse or qualified designated assistant. I also consent to Human Immunodeficiency Virus (HIV) testing if indicated.

I acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made in advance.

We request the payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished for me. I authorize any holder of medical information about me, or my dependent, to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original unit revoked. I understand, and agree to promptly pay any balance remaining after insurance payment.

Patient's / Guarantor's signature ____________ Date ____________ Witness ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

I ______________________________ acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature ____________ Date ____________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtain because:

- ☐ The patient refuses to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment
- ☐ We weren't able to communicate with the patient
- ☐ Other (please provide specific details)

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Employee Signature ____________ Date ____________