SOUTH COUNTY MEDICAL GROUP

GENERAL CONSENT FOR TREATMENT

_____ Patient Name

_____/_____/_____ Date of Birth

Primary Care Westerly Practice Name

GENERAL CONSENT FOR TREATMENT

1. I, the undersigned and/or legal representative or relative, hereby consent to, authorize and request South County Medical Group and its medical personnel to perform ambulatory care services, including but not limited to medical examinations, evaluations, treatments, procedures, diagnostic tests, laboratory tests, vaccinations and immunizations during the course of my or the patient's care as may be deemed advisable or necessary. I understand that I have the right to refuse any suggested medical treatment, examination, evaluation or test at any time.

2. I understand that this consent and authorization for treatment is valid and will remain in full force and effect for the duration of my treatment at this Facility unless and until I revoke or otherwise withdraw my consent in writing.

3. I understand and agree that I am ultimately responsible for all charges associated with the ambulatory care services that I receive at this Facility. In the event that my insurance company does not pay for the anticipated portion of any charges, for any reason, I understand and agree to be responsible for all unpaid amounts.

4. I have been given a copy of and had an opportunity to review and understand the SCCHS Joint Notice of Privacy Practices. I understand and acknowledge that this Notice describes how my protected health information may be used or disclosed for carrying out medical treatment, billing and payment activities and other healthcare operations. I hereby consent to and authorize such use and disclosure of my protected health information.

5. Consent to obtain medication history:
   I understand that an accurate medication history is very important to helping treat my condition and to avoid potentially dangerous drug interactions. I agree that SCCHS may request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ Patient Signature or Authorized Person

___/___/___ Date

_____ Witness Signature

___/___/___ Date

Relationship is signature is not patient _____

Photo ID verified by: _____