Patient Consent

Request for Care and Consent for Treatment

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures, anesthesia or other services rendered to the patient under the general and special instructions of the patient's physician. BayCare Medical Group has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Assignment of Insurance Benefits

I authorize payment directly to BayCare Medical Group of any insurance benefits otherwise payable to me for services, at a rate not to exceed BayCare Medical Group regular charges for such services.

Releasing Medical Information

I understand that BayCare Medical Group, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal health care operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Facility and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment or normal health care operations, review BayCare Medical Group's Notice of Privacy Practices.

Permission for Treatment

Permission is hereby granted for physicians, employees or agents of the Practice to render the patient named below such medical and surgical treatment as is deemed necessary.

The undersigned certifies that he/she has read the forgoing, received a copy therof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

Patient (print name): _____

Signature of patient or authorized person: _____

Relationship: _____ Date: _____

Witness signature: _____ Date: _____

If the patient did not sign, please state reason: _____

BayCare Medical Group