GENERAL CONSENT FOR TREATMENT

I understand that Carolina Family Health Centers, Inc. (CFHC, Inc.) is an integrated healthcare program made up of various entities, including (but not necessarily limited to) Carolina Family Dental Center, Freedom Hill Community Health Center, Harvest Family Health Center, and Wilson Community Health Center.

The following are the conditions for services provided by CFHC, Inc. The general consent for treatment provides CFHC, Inc. with your permission to perform reasonable and necessary medical/dental examinations, testing, and treatment. These conditions and consent will remain fully effective until it is revoked by you in writing. You have the right at any time to discontinue services.

General Consent for Treatment - By signing below, I am indicating that (1) this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and, (2) I consent to treatment at this office or any other satellite office under common ownership. I understand that I have the right to discuss the treatment plan with my provider about the purpose, potential risks, and benefits of any test ordered for me. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I understand if I have any concerns regarding any test or treatment recommended by my healthcare provider, I am encouraged to ask questions.

My signature below indicates that I voluntarily request a physician, dentist, advanced practitioner (Nurse Practitioner, Physician Assistant, or Clinical Pharmacist Practitioner), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical/dental examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional invasive or interventional procedures are recommended I will be asked to read and sign additional consent forms before the test(s) or procedure(s) are performed.

Authorization for Release of Information - I acknowledge that under the Health Insurance Portability and Accountability Act (HIPAA), CFHC, Inc. is authorized to release my medical records to other healthcare specialists, entities, or regulatory agencies to carry out treatment, obtain payment, conduct certain healthcare operations, and comply with federal and state laws.

I give permission to CFHC, Inc. and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or healthcare operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Acknowledgment of Receipt of Notice of Privacy Practices - I acknowledge that I have received a copy or been given the opportunity to review Carolina Family Health Centers, Inc.'s *Notice of Privacy Practices*. I understand, as provided in the Notice, the terms of the Notice may change. I may obtain a revised copy by contacting the Privacy Officer.

Financial Responsibility – I agree to be responsible for my co-payments, deductibles or other charges for services not covered or paid by insurance or other third party payers. I authorize CFHC, Inc. to file any

claims to my insurance, if applicable, for payment of any portion of my bill and assign all rights and benefits to CFHC, Inc. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event CFHC, Inc. takes action to collect the same because of my failure to pay in full all incurred charges. If I have overpaid any of my accounts with CFHC, Inc., I agree that the overpayment may be applied to pay any outstanding charges on any of my other accounts with CFHC, Inc.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request - I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my healthcare under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to CFHC, Inc. on my behalf. I authorize CFHC, Inc. to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to CFHC, Inc.

Authorization to Contact – CFHC, Inc., or their agents or representatives, may contact me by telephone at any number contained in my CFHC, Inc. records, including wireless telephone numbers, for the purpose of servicing my account and collecting amounts due. Methods of contact may include pre-recorded or artificial voice messages and the use of automatic dialing services.

Social Security Number - I have given my social security number voluntarily. CFHC, Inc. may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Personal Property - I understand that CFHC, Inc. does not assume responsibility for my personal belongings that I keep in my possession, and I release CFHC, Inc. from all liability for the loss or theft of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY CFHC, INC., OR IN PROGRESS.

I AUTHORIZE CFHC, INC. TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

_____	_____	_____
Patient's Name (printed)	*DOB*	*MR#*

_____	_____
Patient/Parent/Legal Guardian's Signature *(Parent must sign for minor child)*	*Date*