

MRN: _____

HOWELL ALLEN CLINIC
PATIENT CONSENT FORM

Patient's Name: _____ Social Security #: _____

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedure/tests

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended.
The consent will remain in full force until revoked in writing.

I understand that Howell Allen Clinic includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that Howell Allen Clinic will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient by the attending physician or their assigned designees, such as diagnostic tests or procedures.

Payment includes but is not limited to: the authorization of payment directly to Howell Allen Clinic of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I will provide Howell Allen Clinic with the phone numbers I authorize them to use to contact me. I authorize the use of any messaging person or system, voice mail and/or an answering to machine to convey information regarding my care.

I authorize the use of Faxing or Email to send my information to myself or to other authorized parties that have a right to receive my information. I understand that every effort is made to protect my privacy; however, no absolute privacy guarantee is given when Faxing or Email is used.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Howell Allen Clinic.

I acknowledge that I have been given Howell Allen Clinic Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature

Date