Authorization Form

Patient Information

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Social Security Number:** _____

Consent to Treat for Adult

I, the patient or authorized patient representative, consent to medical treatment from Care One of Florida, its affiliates, health care providers, and employees. Treatment may include any examinations, tests, medical procedures, or other health care services deemed necessary by the health care provider. I understand I may refuse treatment at any time. This consent will remain fully effective until it is revoked in writing.

Signature: _____ **Date:** _____

Name: _____ **Relationship to Patient:** _____

Consent to Treat for Minor

I attest that I am the custodial parent or legal guardian of the above listed minor and hereby consent to medical treatment from Care One of Florida, its affiliates, health care providers, and employees as it so deems necessary to the minor. Treatment may include any examinations, tests, medical procedures, or other health care services. I understand and agree this consent will remain fully effective until it is revoked in writing.

Signature: _____ **Date:** _____

Name: _____ **Relationship to Patient:** _____

Privacy Practice

I have reviewed or have been given an opportunity to review the Care One of Florida Notice of Privacy Practices (NPP). I have had an opportunity to ask questions about it and received satisfactory answers. I may request a copy of the NPP.

Signature: _____ **Date:** _____

Financial Agreement and Insurance Assignment

I authorize Care One of Florida to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurer(s) and that payments be sent directly to Care One of Florida. I authorize Care One of Florida to release information regarding my medical condition, illness, and treatment to receive payment for related services. I understand the amount I pay at the time of service is an estimate and my actual responsibility will not be known until after the claim has been processed by my insurer(s). I understand insurances do not cover all services and some of the services I receive may not be covered by my insurer(s). I understand and agree that any unpaid balance not covered by my insurer(s) will be my responsibility. I understand and agree that I am ultimately responsible for the balance of any services rendered. I understand and agree that I will be responsible for any additional charges for any returned checks.

Signature: _____ **Date:** _____

HIPPA and Release of Information

I authorize Care One of Florida to release the above patient's medical or other information contained in the medical records to the following person(s):

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

☐ I authorize Care One of Florida to leave messages concerning my care on my voicemail

☐ I do not authorize Care One of Florida to leave messages concerning my care on my voicemail

I understand and agree this authorization will remain fully effective until it is revoked in writing.

Signature: _____ **Date:** _____