HALIFAX HEALTH
303 N. Clyde Morris Blvd., Daytona Beach, FL 32114
1041 Dunlawton Ave., Port Orange, FL 32127

Patient Name _____
Physician _____
Date of Birth_____ Gender_____
Med. Record # _____

CONSENT TO RECURRING OUTPATIENT CARE AND RELEASE OF INFORMATION ASSIGNMENT OF INSURANCE BENEFITS ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Consent to Recurring Outpatient Care. I am presenting myself for hospital care, which may include multiple visits for diagnostic testing and/or therapeutic services all related to a single spell of illness or injury. I hereby voluntarily authorize and consent to such care, including any tests, examinations, diagnostic procedures, surgical and medical treatment, or other hospital care which my doctor, the hospital and its agents and employees, or other persons caring for me may judge as necessary and beneficial to me. No guarantees have been made to me about the outcome of this care.

Consent to Assignment of Insurance Benefits and Appeal Rights. I request payment of authorized insurance benefits (health, casualty or otherwise) including Medicare benefits due for any services furnished by or in the hospital, or through one of its affiliated corporations, including physician and contracted services, be made to the providers(s) of the services(s). This is not a specific designation of how payments must be applied. I hereby authorize the hospital to apply any payments made by me and/or on my behalf by a third party payer first toward the account referenced, until satisfied, then to any other existing indebtedness to the hospital. If payment of a claim is denied or reduced by the third party payer, I authorize the hospital or its agent to pursue reconsideration of the claim, an appeal, a fair hearing and/or other remedy on my behalf. I understand that Halifax Health or one of its affiliates may assert a right of subrogation if I recover any amount from a third party related to my medical treatment.

Acceptance of Financial Responsibility and Consent to Review of Credit Reports. I understand that I am responsible for, and agree to pay, upon presentation or demand, any charges that are my responsibility not covered or not paid by any applicable insurance, including reasonable attorney fees if legal action is filed to collect. I understand some fees for physicians, non−physician practitioners and/or contracted services may not be included in my hospital bill. I will receive separate billing for these services as well as from my physician and other practitioners who are involved in my treatment, including, but not limited to, pathologist, radiologist, and anesthesiologist. These bills may include supervisory services for tests performed. I consent to the review of credit reports by the hospital and/or its authorized agents. I understand that I am entitled to a complete detailed billing upon request (§ 395.301, Florida Statutes).

Notice: I agree that in order for Halifax Health or any affiliated agents to service my account(s) or to collect any amounts due, I may be contacted by telephone at any telephone number associated with my account, including wireless telephone numbers that could result in billable charges. Methods for contact may include the use of pre−recorded/artificial voice messages and/or use of an automatic (predictive) dialing service(s), as applicable.

Notice: Although the hospital may participate in your health plan, a physician involved in your care may or may not be a participating provider. This may affect coverage for professional services. We suggest you contact your plan's member services representative for a coverage determination.

Notice: Some of the physicians and other individuals who provide medical care and treatment for Halifax Health are agents of the Halifax Hospital Medical Center tax district. Any liability that may arise from their care and treatment is limited as provided by law.

Use and Disclosure of Protected Health Information. I consent to the use and disclosure of medical information about me for treatment, payment and health care operations as described in the hospital's Notice of Privacy Practices. I understand that I have the right to review the Notice prior to signing this consent. I acknowledge having received the Notice at this or a prior visit.

Use and Disclosure of HIV−AIDS, Mental Health and Substance Abuse Information. I understand that the information used or disclosed as described in the Notice of Privacy Practices may include information about Acquired Immunodeficiency Syndrome (AIDS), AIDS−related complex, tests for or infection with the Human Immunodeficiency Virus (HIV), psychiatric conditions, alcoholism or substance abuse.

I acknowledge that providing false information to a hospital with the intent to defraud the hospital in order to obtain goods or services is a crime under Florida law (§ 817.50, Florida Statutes).

I/we certify that the signature(s) below represent consent and acknowledgement for the above. I/we fully understand the above and agree to all terms stated herein.

_____ _____ _____
Signature of Patient / Guardian / Representative Date Time

_____ _____ _____
Signature of Witness Date Time

PATIENT UNABLE TO SIGN BECAUSE: _____

_____ _____
Signature of Witness Date

GEN CONSENT