

**HCA Physician Services  
Center for Advanced Medical Care  
Patient Consent Form**

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this given in advanced of any specific diagnosis or treatment.

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 Center for Advanced Medical Care may include consent at satellite offices under common ownership.

I, the undersigned, authorize the Center for Advanced Medical Care to use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

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

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient to please check with your insurance company regarding your coverage. It is your responsibility to know your individual coverage. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is between you and your insurance company, not between your doctor and your insurance company. In the event my insurance does not pay for all costs incurred, I will assume full responsibility.

**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 Center for Advanced Medical Care. I acknowledge that I have been given the Center for Advanced Medical Care Notice of Privacy Practices. I understand that if I have any questions or complaints that I should contact the Privacy Officials. Patient initials: \_\_\_\_\_

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

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**Patient (or Responsible Party) Signature**

**Date**