



CONSENT FOR MEDICAL CARE/ASSIGNMENT OF BENEFITS

1. AUTHORIZATION FOR EXAMINATION AND TREATMENT: I authorized the examination and/or treatment considered necessary for me and that the treatment and procedures will be performed by physicians, and/or physicians assistants/nurse practitioners of the Hillcrest Family Health Center, or Associates of Hillcrest Family Health Center. Authorization is hereby granted for such treatment and procedure and the administration of such local anesthetics, medications or other treatment deemed necessary. I certify that I have read the above authorization and understand the same, and also certify that no guarantee or assurance has been made as to the results that may be obtained.

2. ACKNOWLEDGEMENT OF PHYSICIAN ASSISTANT/NURSE PRACTITIONER: I hereby agree to be medically attended, treated and followed by a physician, and/or physician assistant/nurse practitioner, and nursing staff at Hillcrest Family Health Center. The treatment may include physical exam, emergency treatment or services, laboratory procedures, and/or medical/surgical treatment or procedures.

The Physician Assistant is not a doctor. A Physician Assistant is a licensed health care professional who has received training in the provision of medical services. He/or she is under the direct supervision of a licensed physician at all times. Physician Assistants have three or more years of college level training in Health Care Centers or Medical School settings. Physician Assistants are licensed by the Texas State Board of Medical Examiners.

The Nurse Practitioner is not a doctor. A Nurse Practitioner is a Registered Nurse with a Master's Degree in Nursing or a Nurse Practitioner Certificate and advanced clinical training. They are certified by the State Board of Nurse Examiners. A Nurse Practitioner is under the supervision of a licensed physician.

3. ACKNOWLEDGEMENT OF OUTPATIENT TREATMENT: I hereby acknowledge that the medical care that may be furnished to me in the outpatient room of the Hillcrest Family Health Center will be solely limited to outpatient treatment. I understand that I may be released before all of my medical problems are known or treated, and that it will necessary for me to make arrangements for follow-up care.

4. INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payments directly to the Hillcrest Family Health Center for the medical expense benefits otherwise payable to me. I understand that I am financially responsible to the Hillcrest Family Health Center for charges made by them for services rendered.

5. NOTICE OF POSSIBLE NON-COVERAGE: I understand that, in the event of non-coverage by my insurance for any services or items provided during treatment, I am responsible for payment to Hillcrest Family Health Center. I hereby authorized such services/items deemed "reasonable and medically necessary" for my care.

6. PATIENT RIGHTS: I understand that I have the right to participate in my plan of care and treatment. I have the right to refuse treatment and be informed of the consequence of such refusal. I also have the right to personal privacy and confidentiality.

This is a legal consent and assignment of benefits form. Please read it carefully and be sure your questions have been answered before signing.

Signature (Patient/Guarantor)

Today's Date _____

Relationship to Patient

Patient Name

Patient DOB