Carrboro Pediatrics and Internal Medicine

GENERAL CONSENT FOR OUTPATIENT DIAGNOSIS, CARE, AND TREATMENT:

On an ongoing basis, I request, consent, and authorize Carrboro Pediatrics and Internal Medicine (CPIM) to perform diagnostic and therapeutic tests, immunizations and procedures and provide general care and treatment as determined necessary and/or ordered by those healthcare professionals involved in my care. This includes, but is not limited to, the performance of physical examinations as well as the taking of blood, tissues, fluids, or other bodily samples. I also consent and authorize CPIM to examine, use for the purposes for which they were provided, store, and dispose of any blood, tissue, fluids, or other bodily samples in accordance with legal requirements and customary procedures. I understand I may ask my healthcare providers about my care, treatment and procedures at any time and I am encouraged to do so.

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS:

I understand I am financially responsible for all of the charges and bills associated with my care and treatment (including annual deductibles and co-payments) except charges which are covered and paid by health insurance, government healthcare program such as Medicare or Medicaid, a financial assistance program, or any party responsible for payment (all of which are referred to as "Third Party Payers"). I authorize CPIM to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make payments directly to CPIM in response to these bills or claims.

MISSED APPOINTMENTS AND CANCELLATIONS:

Our policy is to charge for missed appointments canceled with less than 24 hours' notice at a rate of $60.00. This fee is not covered by your insurance plan and is your responsibility. Our policy, at the discretion of the provider, is to terminate a patient from the practice after 3 missed/canceled (without 24 hours' notice) appointments.

CONSENT AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:

CPIM maintains health records in electronic and other forms. These records describe, among other things, my past and current health status, including the diagnoses of any illnesses and conditions, the nature and results of examinations and tests, treatment provided, and any plans for care or treatment. In addition, these records include billing, social, and other identifying information and may include sensitive information such as genetic testing results, HIV/AIDS status, and drug or alcohol use (all of which is referred to as my "Health Information"). I consent and authorize CPIM, when necessary for my treatment, payment of my bills, or CPIM's business operations, to release and exchange my Health Information with other healthcare professionals and organizations involved in my care for the same reasons.

ANY QUESTIONS I HAD ABOUT THIS CONSENT FORM HAVE BEEN ANSWERED.

I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SET FORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT IN WRITING, WHICH I MAY DO AT ANY TIME.

*Signed: _____
Date: _____

Patient ***or*** *Authorized Representative

*Relationship of Authorized Representative: _____
(Parent, Guardian, or Healthcare Agent)