

Superior Medical Clinic, LLC dba



Patient Consent Form

(Please Read and Sign)

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/tests 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 is given in advance 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 **Genesis Medical Clinic** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Genesis Medical Clinic** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

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

Consent for Insurance Policy:

Genesis Medical Clinic will submit claims to the insurance companies that they are contracted with. I understand that I am responsible for all deductibles, copays, and charges not covered by insurance at the time of service. I also understand that I will need to bring my Insurance card at each visit along with my cost that the insurance does not pay.

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 **Genesis Medical Clinic**.

I acknowledge that I have been given the **Genesis Medical Clinic** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial: _____

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

Patient (or Responsible Party) Signature

Date