Abbeville Internal Medicine

A Division of Abbeville County Memorial Hospital

PATIENT CONSENT FORM

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you and your rights with respect to your health information. You have the right to review our notice before signing this consent. As stated in our notice, the terms may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. The revised notice will also be posted in our waiting room.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.
By signing this form, you also acknowledge that you have received or reviewed a copy of the **Notice of Privacy Practices.**

FAX PRIVACY WAIVER

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve this practice of all liability.
I give consent to fax my record for the purposes of treatment, payment, or health care operations and understand that I may withdraw this consent at any time in writing.

I have received information regarding the providers of care in this organization, a copy of the **Patient's Bill of Rights and Responsibilities,** and information regarding the grievance process.

Financial Policy

I certify that I have read the **Financial Policy,** and I will comply with this Financial Policy. I acknowledge full financial responsibility for the service provided to me or my minor children by **Abbeville Internal Medicine.** I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including co-payments, co-insurance, deductibles, and non-covered services. I understand that I am responsible for prompt payment of all charges in the event that I do not have health insurance or that Abbeville Internal Medicine is not a participating provider with my health insurance. I consent to the assignment of authorized insurance benefits by my health insurer to **Abbeville Internal Medicine** for any services furnished to me or my minor child.

If the patient is under 18 years of age or is otherwise incompetent to consent, this document must be signed by the patient's parent, legal guardian, or other duly authorized representative.

Consent for Treatment

I _____ give Abbeville Internal Medicine consent to medical treatment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship to the Patient