**CONSENT FOR TREATMENT**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby consent to examination and/or treatment by Redpoint Medical, PSC, including and/or therapeutic procedures ordered by the physician.

As part of the medical procedures or tests authorized by the physician, I consent to be tested for human immunodeficiency virus infection (AIDS), hepatitis, or any other blood-bourne infectious disease for purposes directly related to my medical treatment. If a health care worker is exposed to my blood or bodily fluids, Redpoint Medical, PSC may, at its cost, test my blood for any infectious disease. Redpoint Medical, PSC shall confidentially maintain to the extent provided by applicable law: a) the fact that a blood test was ordered, and b) the results of such tests.

ASSIGNMENT OF BENEFITS: I authorize direct payment of benefits payable on my behalf to Redpoint Medical, PSC. I further authorize release of information required by any third-party payor regarding this claim. I permit a copy of this authorization to be used in place of the original.

Patient Signature: Date:

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