CONSENT TO TREATMENT

I, _____ (patient name), do hereby give consent for County Med, LLC and its staff to provide medical treatment for me including but not limited to assessment, evaluation, diagnostic procedures, and referrals.

I understand that some findings or results may be legally reportable without my consent.

I understand that should at any time, someone be exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with the Human Immunodeficiency Virus (HIV), Hepatitis B/C, and/or other diseases as deemed necessary.

I authorize the release of my information as necessary for purposes such as sharing between treatment providers, information necessary for referrals, and release to insurance companies for billing purposes or as otherwise required by law.

I consent to the use of electronic prescribing for my prescriptions.

I acknowledge that I am the financial party responsible for this visit. I authorize the release of my information as necessary to bill for services provided. I understand that I am responsible for my share of the costs as determined by insurance. I understand that I am responsible for any fees for services provided by this office that are not covered by my insurance company or if I do not have insurance.

I request that payment of authorized insurance benefits be made on my behalf to County Med, LLC for any services provided to me.

I authorize the direct payment of any monies or benefits be made directly to County Med, LLC for any and all services provided to me as a patient. I understand that should a payment be made directly to me for services provided, I will submit said payment via cash or electronic payment to County Med, LLC within 10 business days of receipt of payment.

I agree, in the event my account becomes delinquent, to pay the balance due along with any incurred interest, penalties, collection fees or legal fees incurred in an effort to obtain payment.

Patient Name (Printed): _____

Patient/Parent/Guardian Signature: _____

Relationship (if signed by someone other than the patient): _____

Date: _____