FLORIDA DEPARTMENT OF HEALTH

INITIATION OF SERVICES

PART I CONSENT FOR CARE, TREATMENT AND INFORMATION DISCLOSURE (TREATMENT, PAYMENT OR OPERATIONS)

Client Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering into a client-provider relationship. I understand the relationship is confidential and voluntary and that I may discontinue the relationship at any time. I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART II ADDITIONAL METHODS OF COMMUNICATION – You may provide other means of communication. Each form of communication presents unique risks for unintentional disclosure. In addition to my home address, I authorize you to optionally contact me for appointment reminders and other medical or dental matters by the below method(s):
Initials

_____ mailed to this address: _____, _____, _____, zip _____

_____ by a phone call to one of these numbers: #____-_____-_____, #_____- _____-_____, Cell Phone #_____- _____-_____

_____ other means of communication: _____

_____ **TEST** Results (excluding HIV, or minor family planning) may be mailed to me at home or the above addresses.

_____ **FAX --** I authorize my medical information to be faxed to others for payment or healthcare operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

_____ _____ _____
Client/Representative Signature | Self or Representative's Relationship to Client | Date

_____ _____
Witness (optional) | Date

PART VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature | Date

_____ _____
Witness (optional) | Date

Client Name: _____

ID#: _____

DOB: _____