MISSION EAST DALLAS
FAMILY HEALTH CLINIC

Patient General Consent / Acknowledgement Patient ID Number _____

Patient Initials

_____**NOTICE OF FINANCIAL POLICIES**

Mission East Dallas will charge persons receiving health services at the usual and customary rate prevailing in this area. Health Services will be provided at a reduced charge to qualified persons unable to pay full price for services. In addition, persons will be charged for services to the extent that the payment will be made by a third party authorized or under legal obligation to pay the charges.
Mission East Dallas will not discriminate against any person receiving health services because of their inability to pay full price of services or because payment for the health services will be made under the Medicare or Medicaid programs, as we have agreements in place to accept assignment and provide services for which payment may be made under these programs.

_____ **INSURANCE PAYMENT AUTHORIZATION & FINANCIAL AGREEMENT**

I accept financial responsibility for all treatment provided by Mission East Dallas. I authorize Mission East Dallas to release any information provide to my insurance companies that may be necessary to process insurance claims. I hereby authorize my insurance benefits to be paid directly to Mission East Dallas and acknowledge that I am financially responsible for any unpaid balances. A photocopy or scanned image of this authorization shall be considered as valid as the original.

_____ **GENERAL CONSENT FOR CARE AND TREATMENT**

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

_____ **CONSENT STATEMENT:**

I voluntarily request a physician, dentist, and/or midlevel provider Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examinations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify and acknowledge that I have read and fully understand the above statements and consent fully and voluntarily to its contents. A photocopy or scanned image of this authorization shall be considered as valid as the original.

Patient Signature _____ Date _____

Printed Name: _____