PREMIUM CARE MEDICAL CENTER, LLC

PATIENT CONSENT FORM

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to allow Premium Care Medical Center to use and disclose my Protected Health Information in order to carry out medical treatment, payment and healthcare operations.

Authorization/Insurance Payment

- I authorize Premium Care Medical Center to provide medical information to my insurance carrier and I authorize payment of insurance benefits to the Premium Care Medical Center for services provided to me.

Authorization to Leave Voice Messages and/or Email

- I authorize Premium Care Medical Center to leave messages by voice or email or text at my home or employment reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand, however, that no message will be left regarding confidential medical information unless specifically authorized by my doctor and myself.

By signing this form, I am consenting to Premium Care Medical Center's use and disclosure of my protected medical information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. I understand that I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent.

RECORDS REVIEW FOR RESEARCH

- I also authorize Premium Care Medical Center to review my records to determine my qualifications for approved clinical studies and to contact me if I have potential as a research candidate. No records are ever provided to other persons for research purposes, except by specific written approval from me.

FINANCIAL RESPONSIBILITY

- I accept financial responsibility for all charges for medical care provided to me and/or my family members by the physicians and medical staff of this clinic.

CONSENT TO TREATMENT BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER*

- I agree to be treated by the Physician Assistant or a Nurse Practtioner, a healthcare professional licensed by the Louisiana State Board of Medical Examiners. A Physician Assistant or Nurse Practitioner is incorporated by Premium Care Medical Center to provide an additional level of access to high quality patient care.
- I understand that I may change this decision at any time by requesting to see a physician, at which time the Clinic will assist me in scheduling my care.

  *If you would like additional information about Physician Assistant or Nurse Practitioner services and training, please ask the receptionist.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian