Acknowledgment of Consent

By executing this agreement, I accept the following terms of treatment that are required by Family Medical Center of Hart County (FMC):

Consent for Medical Treatment: I consent to routine diagnostic procedures and medical treatment by Family Medical Center of Hart County. I understand that no guarantee of results has been made.

Protected Health Information: I consent to the use and disclosure of my protected health information, by Family Medical Center of Hart County, to carry out treatment, payment, or health care operations. I acknowledge receipt of a copy of the HIPAA Privacy Notice which provides a complete description of such uses and disclosures, and that I have the right to review the policy notice prior to signing this consent.

I understand that I have the right to cancel this consent, in writing, at any time. If I cancel this consent, I understand that information may have already been used or disclosed about me and that only future disclosures will be affected.

Insurance Authorization/Assignment: I assign the authorized benefits of my medical insurance (including any Medicare, Medicaid, or Medigap plans) to be made on my behalf to Family Medical Center of Hart County for any services furnished to me. I authorize payment of the assigned benefits directly to Family Medical Center of Hart County. I authorize Family Medical Center of Hart County to release medical information to the Social Security Administration or its intermediaries or carriers as required for payment of claims.

Family Medical Center of Hart County has the right to change its privacy terms and practices which are described in the privacy notice. A sign will be posted at the front desk to notify patients of any changes and how to get an updated copy.

Patient's Name	**Date of Birth**
Responsible Party (If not the Patient)	**Relationship to Patient (If not the Patient)**
Signature	**Date**