**Trumed Family Clinic Inc.**

**Treatment Authorization and Consent Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Trumed Family Clinic, Inc. (Trumed Family Clinic Inc. refers to Physicians, mid-level providers and associates of Trumed Family Clinic Inc) to provide medical evaluation and management services to me at my home or at the clinic (Trumed Family Clinic Inc. office). I also authorize Trumed Family Clinic Inc. to release medical information related to my care, for the purpose of collecting fee for service from my insurance carriers and any other party/entity involved in my medical care. I authorize Trumed Family Clinic Inc to bill my insurance and receive payment directly for medical services provided to me. I also understand that I will be responsible for any portion of the approved charges that are not covered by my primary and secondary Insurance carriers.

 I further authorize Trumed Family Clinic, Inc. to obtain my medical records and test results that might impact my care from any sources, including but not limited to health care providers, hospitals, radiology services, labs and insurance carrier.

 I also understand that I may be referred to other professional health care providers or services, and consent to any such recommendations as part of my treatment plan. In the event I fail to adhere to my treatment plan or fail to schedule and maintain timely follow up with such referrals, I hereby release Trumed Family Clinic Inc from liability related to any further injury, disability or death resulting from my failure to comply with recommended medical referrals.

 I also understand that Trumed Family Clinic Inc. will use the contact information I provide to send communications to me; written, verbal, phone calls or emails. It is therefore my responsibility as a client to provide updated information in writing to the clinic in the event of any changes in my personal contact information. In the event I fail to maintain updated personal contact information in writing, I hereby release Trumed Family Clinic Inc. from any and all liability that results in injury, disability or death as a result of communications that fail to reach me at the appropriate address, phone number or email.

 In the event of any disputes arising from a treatment plan or medical services rendered by Trumed Family Clinic Inc., I agree to notify Trumed Family Clinic Inc. in writing within a period of 30 days and agree to submit the unresolved dispute to arbitration services for final and binding resolution.

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**