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**CONSENTS AND CONDITIONS**

I consent to have One Stop Medical Clinic’s health care provider to treat me in the clinic. I consent to have (1) physical examination, (2) any necessary diagnostic testing or screening, (3) any necessary medical treatment, and (4) if necessary prescription medication.

I understand that the assessment of my medical condition, or the medical condition of the patient for whom I am responsible, is limited to performing the diagnostic procedure(s) indicated and any recommended treatment is limited to treatment indicated by the result of the diagnostic test(s). I acknowledge and agree that I am being evaluated and treated by a Registered Nurse Practitioner. I acknowledge and agree that results from any diagnostic test will be sent to the address on my account and One Stop Medical Clinic will not send any test results to my regular professional health care provider or any other health care provider, practice or facility except as requested in writing. Any other specific medical questions I have about my or the patient’s medical condition, treatment, care or diagnosis should be presented to my regular professional health care provider.

I hereby assign and transfer all of my rights, entitlement and interest in all benefits and payment now due and payable, or that become due and payable, under my insurance policies, any replacement policies, and any self-insurance program, employers and state welfare funds, or under any other benefit or entitlement plan for related outpatient care to One Stop Medical Clinic or its agents or divisions. In addition, I authorize the release of any medical information deemed necessary to One Stop Medical Clinic or its agents or divisions to my insurance carrier or any entitlement program provider in order to determine the benefits applicable to this date of service. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including Medicare, Medicaid and, delinquent accounts shall bear interest at the legal rate allowed. If One Stop Medical Clinic has an agreement with my health plan or insurer, I understand that I am responsible for paying any co-payment or deductible amount today; I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect any outstanding balances on my account.

I acknowledge that I have received One Stop Medical Clinic’s Notice of Privacy Practices and the Patient Bill of Rights and Responsibilities. I recognize the information gathered by the One Stop Medical Clinic may need to be disclosed to a third party for purposes of administration, treatment, payment and other healthcare operations. I consent to such release.

I confirm that I have read, or have had read to me, this form. I have had all questions related to this form answered and understand the above.

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Patient Name (Please print) Date of Birth

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Signature Today’s Date

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Relationship to patient, if other than signed by the patient Telephone #