# GENERAL CONSENT FOR TREATMENT

Patient's Name: _____ Date of Birth_____

**1). CONSENT**: I request and authorize Health Care Services by my physician, and his/her designees as may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration.

**2). RELEASE OF INFORMATION**: I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Inter American Medical Services to release all information from my medical record to:

Payors, organizations or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my physician(s) bill, and for filing appeals of denial of benefits, so that the physician may be paid for the services provided to me; and Independent auditors or review agencies retained by any third party payors and insurers to analyze the charges for services rendered to me. In order to improve service and provide valuable input, I also authorize Inter American Medical Services to release my demographic information for any type of medical payment/treatment.

**3). VALUABLES**: I understand that Inter American Medical Services is not responsible for valuables or personal articles.

**4) PAYMENT**: I assign and authorize payment, for any and all services rendered, directly to Inter American Medical Services from my insurance company or third party payor including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and workers disability compensation insurance.

In consideration of the professional services provided or to be provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, non-covered services. I understand that it is my personal responsibility to pay Inter American Medical Services all charges for services rendered despite of any disputes or disagreements between my insurance company and myself.

X_____ _____

Signature of Patient or Guardian Date