BAY CLINIC FAMILY HEALTH CENTERS
CONSENT TO TREAT

I authorize the employees of Bay Clinic, Inc. to render primary care and related services. I understand Bay Clinic is committed to offering superior quality of care to all patients regardless of race, ethnicity, religion, sex, age, or handicap status.

I understand that I will be fully informed of anticipated benefits, possible discomforts, and potential side effects prior to the performance of any medical treatment, and I release The Health Center from liability that may arise as the result of such treatment, unless due to sole negligence of its staff. I consent to examinations, treatments, procedures and blood tests ordered by my physician and health care providers, including blood tests for communicable diseases such as hepatitis and HIV/AIDS.

I understand my medical record and information related to my care at Bay Clinic is confidential. I have been provided a Summary Notice of Privacy Practices that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law, as applicable. I understand that state law requires the reporting of certain positive results such as hepatitis and the antibody for the AIDS virus to the health department. I authorize the release of any medical or other information necessary to process a claim for payment. This notice is in compliance with the guidelines set forth in the Health Insurance Portability and Accountability Act. (HIPAA) of 1996, effective April 14th, 2003.

I authorize release of information to all third party payors or health and social service agencies, as well as Medicare and authorize Bay Clinic, Inc. to bill my charges to Medicare. I understand that I am still responsible for my bill even though I may have health insurance.

I understand that I will be asked to provide proof of income at least once each year so my charges can be accurately calculated for the sliding fee schedule. I understand that I must present a current public aid card, health insurance, or Medicare card at each visit to Bay Clinic, Inc. when my charges are covered.

I hereby assign, transfer and set over to Bay Clinic, Inc. all of my rights, title and interest to my medical reimbursement benefits under my insurance policies.

The above information is true and correct. This information is subject to review and verification.

I understand that I must provide written documentation to support this information; and that if I do not provide the documentation, or if I falsify information, services can be terminated.

I agree to notify Bay Clinic, Inc. of any changes in my household income information by the first appointment after the changes have occurred.

Patient Name: _____ **Patient Date of Birth**: _____
Printed Name

Signature of Patient, Parent or Guarantor: _____ Date: _____

Witness: _____ Date: _____