CONSENT FOR CARE

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I authorize Dublin Family Care, Inc. and any employee working under the direction of a physician to provide medical care for me, or to this patient for whom I am the legal guardian. This medical care may include services and supplies related to my health (or the health of the identified person) and may include but not be limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body. This consent includes contact and discussion with other health care professionals for care and treatment.

RECEIPT OF NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES
I have been given the opportunity to receive a copy of Dublin Family Care, Inc.'s Notice of Patient Rights and Responsibilities. I understand that the terms of the Notice of Patient Rights and Responsibilities may change and I may obtain these revised notices by contacting the practice by phone or in writing.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
I have been given the opportunity to receive a copy of Dublin Family Care, Inc.'s Privacy Notice. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing.

RECEIPT OF NOTICE OF FINANCIAL POLICY
I have been given the opportunity to receive a copy of Dublin Family Care, Inc.'s Financial Policy. I understand that the terms of the Financial Policy may change and I may obtain these revised notices by contacting the practice by phone or in writing.

ASSIGNMENT OF BENEFITS
I hereby assign to Dublin Family Care, Inc. any insurance or other insurance company benefits be made on my behalf for any services furnished me by the practice for health care services provided. I understand that the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward to the practice all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

RELEASE OF INFORMATION
I authorize Dublin Family Care, Inc. to release all medical information requested by my health insurance carrier, Medicare or any other third-party payers. I authorize the practice to release all medical information to my referring physician and or primary care physician. I authorize the practice to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to the practice. In addition, I authorize my medication history to be obtained in an electronic format.

I understand that I have the right to refuse to sign this consent or revoke this consent at any time. I am aware that the Practice may refuse to treat me (as long as it is not life threatening). I am aware that if I refuse to sign the consent for operations, payment, or treatment and the practice provides treatment to me; I will become "Self Pay" as the practice cannot bill the insurance carrier without a signed consent.

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Patient's Name (Please Print)	Patient / Guardian Signature	Date of Birth	Today's Date