

## CONSENT FORM

Must read and sign consent before services are rendered



## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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I hereby give my consent for Lifeboat Medical Associates to use and disclose protected health information (PHI) about me or my child(ren) to carry out treatment, payment, and healthcare operations (TPO). Lifeboat Medical Associates Notice of Privacy Practices provides a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of Lifeboat Medical Associates Notice of Privacy Practices is provided in your new patient package and available upon request. Lifeboat Medical Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Lifeboat Medical Associates, 1201 Georgian Park, Peachtree City, GA 30269 ATTN: Privacy Officer.

With this consent, Lifeboat Medical Associates may call my home or other available numbers and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, referrals, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Lifeboat Medical Associates may mail, fax, or e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statement as long as they are marked PERSONAL AND CONFIDENTIAL.

I have the right to request that Lifeboat Medical Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound to this agreement.

**By signing this form, I am consenting to Lifeboat Medical Associates use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lifeboat Medical Associates may decline to provide treatment to me.**

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Signature of Patient

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Signature of Legal Guardian

## WELCOME TO LIFEBOAT MEDICAL ASSOCIATES BROCHURE

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I have read and understand the information in the Welcome to Lifeboat Medical Associates brochure and have had the opportunity to have any questions addressed.

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Signature of Patient

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Signature of Legal Guardian

## WELLNESS EXAMS AND NON COVERED SERVICES

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The healthcare providers at Lifeboat Medical Associates believe that wellness exams are important to the health and well being of our patients. We encourage all patients to schedule and to keep their physical appointments.

Many insurance plans do not pay for preventative medical visits, or for medical services that are not deemed medically necessary. Any question related to your coverage limitations should be directed to either your employer or to your insurance company.

**By signing this waiver you agree to be fully responsible for payment of your services here, if such services are not covered by your insurance carrier. This includes, but is not limited to, laboratory tests, preventative or well visits, procedures, injections, and immunizations.**

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Signature of Patient

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Signature of Legal Guardian