

Client's Name: _____
SSN: _____
Location: _____



Corporate Office
Horizon Healthcare Center, LLC
d/b/a Paragon Family Practice
125 E. Maxwell Street, Suite 300
Lexington, KY 40508
Phone: 859-278-8772
Fax: 859-276-3565

CONSENT TO CARE

- I, _____, consent to be provided with the healthcare offered by Horizon Healthcare Center, LLC, d/b/a Paragon Family Practice, hereinafter collectively known as HHC. I will permit HHC and its employees caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, including tests for reportable communicable disease, examinations, and medical and surgical treatments.
- I acknowledge that no guarantees or assurances have been made or will be made with respects to the results of any such examinations, tests, or treatments, or the benefits, risks, or side effects thereof. Kentucky State Law (KRS 214.625) established procedures affecting human immunodeficiency virus (HIV) or hepatitis B or hepatitis C viruses. In the event that a caregiver is exposed to a client's blood or body fluids, HHC is authorized to test the client for human immunodeficiency virus (HIV) or hepatitis B or hepatitis C viruses. HHC is also authorized to release the test results to the exposed caregiver.
- I acknowledge that if the caregiver is exposed to my blood or body fluids in the course of treatment, my blood will be tested for human immunodeficiency virus (HIV) or hepatitis B or hepatitis C viruses, and the results released to the exposed caregiver. If I am exposed to the blood or body fluids of a caregiver in the course of treatment, the caregiver's blood will be tested for human immunodeficiency virus (HIV) or hepatitis B or hepatitis C viruses, and the results will be released to me.

Authorization for Release of Medical Information

- I UNDERSTAND THAT MY MEDICAL INFORMATION IS CONFIDENTIAL AND IS PROTECTED BY A PROVIDER /PATIENT PRIVILEGE, AND I AM WAIVING THE PROVIDER/PATIENT PRIVILEGE FOR HORIZON HEALTHCARE CENTER, LLC (HHC).
- I consent and authorize HHC to release all information contained in my financial and medical records, including information about communicable disease and serious communicable diseases and infections as defined by Kentucky statute and department of Public Health rules, which include venereal disease (VD), tuberculosis (TB), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS-related complex (ARC) to:
- any of my treating practitioners;
 - any third-party payor or insurance company (including, but not limited to, Medicare, Medicaid, maternal and infant health, commercial insurers, automobile no-fault insurers, worker's disability compensation insurers, and health maintenance organizations) which may be responsible for whole or in part for paying for my health care services;
 - any other person or entity that is responsible for administration, billing, and collecting;
 - any other hospital, treating practitioner, or care facility that will provide subsequent medical/health care to ensure continuity of my care; and
 - any durable medical equipment vendor or product supplier that requires my medical records to justify services.

Financial Responsibility

- I understand that regardless of my assigned insurance benefits, I am responsible for payment of the total charges for services rendered if they fall outside the scope of the health care agreement. I agree that all the amounts for which I am responsible are due upon request, or payment arrangements made between HHC and myself, and are payable to HHC. I certify that any information reported to HHC relating to health insurance or the lack thereof is true, correct, and complete to the best of my knowledge.

This authorization will apply to the anticipated period of treatment and shall remain valid until HHC receives written notification that these authorizations, waivers, and comments have been rescinded. A photocopy of this authorization may be accepted in lieu of the original.

Printed Name of Client or Responsible Party

Signature of Client or Responsible Party

Date Signed

Signature of Witness

Date Signed

Advised of Practice \$25.00 No-Show Policy: _____ (initial)