Quality Medicine LLC, W. Scott Curtice MD

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Please read the following information, initial, and sign this form as indicated. If you have any questions or concerns, please ask our staff.

Patient Name______________________________________DOB____/____/________

Consent to Treatment / Release of Information:

I consent to treatment by Quality Medicine LLC staff according to their policies and my rights as a patient. I give Quality Medicine LLC my permission to release my (or dependent's) personal health information to third parties in order to process requests for payments and to release my information to other providers, in accordance with HIPAA policies in order to coordinate my healthcare.

Advanced Directives (Living Wills):

I have the option of talking with my healthcare provider at Quality Medicine LLC about my wishes about end of life care (sometimes called a Living Will) in the event of serious illness or injury. Quality Medicine LLC staff can provide me with more information about creating an Advanced Directive Document.

I would like more information about these Directives at this time.____Yes____No

Financial Responsibility / Assignment of Benefits:

Direct Primary Care Medicine Model. No insurance plans are accepted, but you may submit out receipts for reimbursement. I acknowledge and accept financial responsibility for all services rendered me (or dependent). I authorize the use of my signature (below) on all submissions. I understand that I am responsible for all fees and charges.

I have read the above information, or it was read (and/to translated to me) and I understand and consent to the policies stated above.

____ ____/____/________
Signature of Patient, Parent, or Guardian Date

____ I am the______Parent______Guardian
Print Name