



INITIATION OF SERVICES

PART I CONSENT TO RELEASE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

Client Name: _____

Name of Agency: Volusia County Health Department Dental Clinic

Agency Address: 1845 Holsonback Drive, Daytona Beach, FL 32117

I consent to the use and disclosure of my medical information; including medical, dental, tuberculosis, sexually transmissible disease, HIV/AIDS, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART II ALTERNATE METHODS OF COMMUNICATION - Each form of communication presents unique risks for unintentional disclosure.

I request contact with me for appointment reminders and other medical or dental matters be:

Initials

_____ mailed to my home address: _____, _____, _____, zip _____

_____ mailed to this address: _____, _____, _____, zip _____

_____ e-mailed to this e-mail address: _____

_____ by a phone call to one of these numbers: # _____ - _____ - _____, # _____ - _____ - _____, Cell Phone # _____ - _____ - _____

_____ **LABORATORY TEST** Results (excluding STD, HIV, TB, or minor family planning) may be mailed to me at any of the above addresses.

FAX --

_____ - I authorize my medical information to be faxed to others for treatment, payment or healthcare operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT WITHIN THE LAST TWO YEARS OF AN ELECTRONIC OR PAPER COPY OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature

Self or Representative's Relationship to Client

Date

Witness (optional)

Date

PART VI WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature Date

Witness (optional)

Date

Client Name: _____

ID#: _____

DOB: _____