PRISAT . P.A.
Prita Madkaiker, M.D.
3685 Crown Point Ct
Jacksonville, Fl 32257

GENERAL CONSENT FOR TREATMENT

I request and authorize medical care from my physician, his assistant or designees that may deem necessary or advisable. This care may include, but not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine medications, biological and other therapeutics, and routine medical and nursing care. I authorize the practice to perform other additional or extended services in emergency situations if it may be necessary or advisable to preserve my life or health.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedure or treatment.

I understand and have been informed that an HIV test may be performed on me without my consent if a health professional or employee of the practice sustains an exposure to my blood or other body fluid.

I understand that as a part of my healthcare , PRISAT.P.A ,originates, maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. This information serves as a basis for planning my care and treatment,
A means of communication among the health professionals who contribute to my care
A source of information for applying my diagnosis to my bill
A means by which a third-party payer can verify that services billed were actually provided.

I hereby authorize and instruct my insurance carrier to make payments directly to PRISAT.PA. and its providers for benefits otherwise payable to me. I agree to personally pay for any charges that are covered by or collected from any insurance company, including any deductibles and coinsurance amounts.

ACKNOWLEDGMENT OF PRIVACY PRACTICES.

I understand that my protected health information , including information about HIV, AIDS, substance abuse treatment records may be disclosed to health professionals who contribute to my care and treatment. I have been offered an opportunity to review the Notice before signing this consent. I have had the opportunity to ask questions and had these questions addressed.

Signature of Patient_____ Date _____

Name of Patient _____