AdexonCare
COMPASSION
INTEGRITY ACCESSIBLE

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CONSENT TO EVALUATE, DIAGNOSE, AND TREAT

Thank you for choosing Adexon Care. Our main concern is that each patient receives quality care. To prevent any misunderstanding and to serve our patients better, we ask that all patients read our policies. If you have any questions or concerns, please do not hesitate to ask.

Consent to Treatment:

I understand that a physician, at my request, will order all test and treatment at Adexon Care. I understand that medicine and any procedures are not an exact science and that there is no guarantee that the outcome of my treatment will be what I want it to be. Knowing this, and agreeing to this, I request to be a patient at Adexon Care. I consent to all necessary testing and treatment while I am a patient at Adexon Care. I authorize Adexon Care to retain and dispose of any specimen or tissue taken from the below named patient.

Patient Privacy Practices:

I authorize Adexon Care to release information acquired in the course of any examination or treatment to physicians and billing services, insurance companies, or their agents for reimbursement purposes, other institutions or organizations performing special test or providing special equipment, supplies or transportation and to local, state, or federal agencies in accordance with applicable law to other healthcare facilities.

Accidental Exposure of Healthcare Workers:

I understand that Texas law provides, and I agree, that if any healthcare worker is exposed to my blood or other bodily fluids, to allow Adexon Care to perform test on my blood or other bodily fluids to determine the presence of any communicable diseases. I understand that such testing is necessary to protect those who will be caring for me while I am a patient at Adexon Care. I understand that the result of tests taken under these circumstances do not become part of my medical record.

Financial Policy:

I have read and understand the Financial Policy of Adexon Care. I agree that if I fail to make any of the payments for which I am responsible in timely manner, I will be responsible for all cost of collecting monies paid, including but not limited to return items fees, collection agency fees, court cost and attorney fees. I agree that any amount owed after my insurance processed my claims is my responsibility.

Lab and Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

I have read and fully understand the above information. I hereby consent to evaluation, testing and treatment as directed by the physician or those under his supervision.

Patient/Authorized Person_____ Date_____