Dillon Internal Medicine Associates, PA AUTHORIZED SIGNATURES

PATIENT'S NAME: (Last, First, Middle)_____

SOCIAL SECURITY:_____ACCT.#_____DATE:_____

I. NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

Should an employee be exposed to my blood/body fluid in a way that might allow transmission of infection due to blood borne disease (i.e. HIV, Hepatitis B, etc) or other communicable diseases, then I understand that ACCORDING TO SC STATE LAW, for the safety, health, and possible treatment of our employees, samples of my blood or body fluid may be tested for evidence of infection.
I also understand that Dillon Internal Medicine Associates employees and physician(s) are obligated to submit to blood tests for certain infectious diseases (i.e. HIV, Hepatitis B, etc) if I am inadvertently exposed to their blood or body fluid during the course of my treatment in the hospital or office.

II. LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE PATIENTS AND RELEASE AUTHORIZATION FOR PRIVATE INSURANCE AND OR PHYSICIAN REFERRALS.

_____ _____
PATIENT'S NAME (Last, First, Middle) MEDICARE # IF APPLICABLE

"I request that payment of authorized Medicare benefits and any other carrier be made either to me or on my behalf to Dillon Internal Medicine Associates for services furnished me by the physician/provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and any other carrier and its agents any information needed to determine these benefits payable for related services."

_____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE

III. RELEASE OF MEDICAL INFORMATION OR RELATED DATA:

"I hereby authorize Dillon Internal Medicine Associates to release or to release from any physician, his/her office, or any other medical facility information necessary for referral purposes." This authorization shall remain in force until written notice is given from the patient or responsible person.

IV. GENERAL CONSENT FOR TREATMENT

I Hereby authorized the physicians of Dillon Internal Medicine Associates, his/her staff to perform and do hereby consent to such medical treatment as he/she feels is necessary, including diagnostic procedures, medical examinations and treatment as may, in his/her opinion, be medically necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment or examination.

V. I consent to photographic documentation of my procedure/ condition, when necessary or required, to be used for educational or insurance purposes.

VI. I do understand I am responsible for payment of any outstanding balance; including non covered service, deductibles co-pays, etc. Also, I agree to abide by the Office and Billing Policies for Dillon Internal Medicine Associates.

VII. **ADULT OR IF MINOR (Under 18 years of age):** The following person(s) is authorized to bring this patient to our practice for medical care and receive PHI _____ _____

VIII. I acknowledge receipt of this practice's Privacy Policy and Procedures.

I hereby acknowledge that I have read or been explained Section I through VI listed above and have been given the opportunity to ask questions.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE SIGNATURE OF WITNESS