HEALTH DEPARTMENT AUTHORIZATION FOR MEDICAL/ DENTAL SERVICES AND PARTICIPATION CONSENT

Place client label here

This certifies that____ may participate in the Alachua County Health Department medical and/or dental services programs. The Health Department medical program offers the following services: Medical History, Medical Examinations, Nutritional and Health Education, and limited laboratory diagnostic screenings for medical clients. The Health Department Dental program offers the following services: adult and child oral exams, cleanings, x-rays, fillings, and extractions. The program also offers sealants to children under twenty-one.

The Alachua County Health Department utilizes a clinic arrangement with several levels of providers. I understand that with certain procedures, a person other than a licensed physician may carry out treatments and other activities, but all such persons will be fully trained in their field and directed by a licensed physician. By signing below, I am giving consent for all present and future treatments and medication administered to me, my minor or ward by the Alachua County Health Department.

I understand that I might be referred for specialty care, lab tests, and diagnostic studies or for hospitalization for a higher level of care. If this is needed I will be responsible for payment of any such services rendered. I understand that the Alachua County Health Department will provide limited basic laboratory diagnostic tests annually to me. The cost of additional lab tests and/or radiographic or other diagnostic tests will be the patient's responsibility.
Medications are not provided by the Health Department.

I have read and understand this consent form and I hereby authorize payment of medical benefits to the undersigned physician/supplier for services described on all claims submitted on my behalf. I also request benefits to be paid to the party who accepts assignments as listed on the claim. I will be responsible for paying all insurance co pay's and unpaid balances by my insurance carrier. I understand that the Department of Health financial policies require that my account be referred to a collection agency after three billing cycles with an unpaid balance.

Signed____Date_________________________

Relationship___________________________Witnessed____

I, ____consent to statements for all services to be mailed to the address provided below.

Client label or ____
Street Address City State Zip
Client or Guardian Signature____
Rev TAP 4/12/2017