Family Medical Group of Texarkana

Universal Consent for Treatment

Medical and Surgical Consent- The undersigned (patient or patient's representative) consents any medical or surgical treatment, x-rays examination, laboratory procedures (including testing for communicable diseases such as hepatitis, venereal disease, Acquired Immune Deficiency Syndrome (AIDS), anesthesia, or hospital services rendered the patient under the general and special instructions and orders of the physician. The undersigned recognizes that all doctors of medicine, dentists and other member of the Medical and Allied Health Staff furnishing services to the patient, including among others radiologists, pathologist , anesthesiologists and the like are not employees or agents of Family Medical Group.

Financial Responsibility / Insurance Assignment- I assign to Family Medical Group any benefits payable for my treatment under hospitalization, medical, dental, accident, or any other form of benefit that I may be entitled to including coverage under any type of plan, trust, or fund that provides benefits to me. I assign such benefits whether they are provided to me as an employee or otherwise and whether such benefits are insured or not insured. I permit any such assignment of benefits that is permissible under state or federal law. If my treatment was caused by events which result in legal action, I assign to Family Medical Group and also authorizes applicable health care benefits, if any, be paid to licensed physicians, individuals, or groups, who perform services for my care and treatment at Family Medical Group. I understand that I am ultimately responsible for this account, regardless of any amount my insurance and/or Workers' Compensation may or may not pay. I agree to pay all fees and charges made for these services, which may include the cost of collection and/or reasonable attorney's fees.

Patient Notice- I have received a copy of the HIPAA notice provided to me by Family Medical Group of Texarkana.

I Have Read and I Understand the Information Above

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Patient or Responsible Party	Date