ZIMA MEDICAL GROUP
INTERNAL MEDICINE PRACTICE

Consent for Treatment

Please read the following information carefully. After you have read this Consent and Agreement, please sign your name below to accept the terms of this agreement.

1. **General Consent for Treatment**: as a consenting adult, I voluntarily consent to and authorize such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications ("Treatments"), by employees and authorized Physicians of **Zima Medical Group PLLC** as may be considered necessary or advisable in their professional judgment, and may include the drawing and testing for HIV (the virus that causes AIDS) and other blood borne diseases. I further acknowledge that no guarantees have been made regarding the effect such Treatments on any medical condition.

2. **Right to Refuse Treatments:** I understand that I have the right to make informed decisions regarding all care and treatments and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any Treatments that I do not want.

3. **Assignment of Benefits / Financial Responsibility:** Authorize and Assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and disability benefits, directly to **Zima Medical Group PLLC** for services rendered. I further assign the proceeds of any settlements, judgments or verdicts from third party liability claims for injuries treated by **Zima Medical Group PLLC** to the Clinic in an amount equal to the outstanding balance of all charges due and owing. I agree that any excess payments may be applied by **Zima Medical Group PLLC** to satisfy any outstanding accounts resulting from prior admissions or treatments. As the patient, responsible party, or guarantor of payment for patient, I agree to be responsible for all charges not covered by the patient's insurance coverage or other claims. I further agree that in the event payment is not made in full for all **Zima Medical Group PLLC** charges, that to the extent permitted by applicable law, I shall pay all Clinic costs of collection including reasonable attorney's fees and/or collection agency fees.

4. **Follow – Up Appointments:** In certain situations we may ask patients to return to **Zima Medical Group PLLC** for a follow up appointment. We provide acute, non-emergent care, as well as management of any chronic illness or disease.

5. **Notice of Privacy Practice: Zima Medical Group PLLC** may release information to other entities or healthcare providers for treatment, payment of services, and for healthcare operations as described in the "Notice of Privacy Practice". **Zima Medical Group PLLC** have prepared this detailed document to help you better understand our polices in regard to the use and disclosure of your personal information.

By signing below; I am indicating that I have read and I understand the terms of this Consent and Agreement for Treatment. I am either the patient or have the authority to give consent on behalf of the patient. I give consent for **Zima Medical Group PLLC** to perform necessary or appropriate care for proper physical examination, diagnosis, and treatment. My questions regarding this Consent and Agreement have been answered.

Signature:_____ **Date:**_____
Patient or Patient representative

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