HCA Physician Services
Kirkwood Medical Associates
4001 Preston Ave, Suite 100 & 110
Pasadena, TX 77505

Phone Message Consent

I give permission for **Kirkwood Medical Associates** to call me or leave me a message for the purpose of notification of results or reminders of appointments at the following number(s):

_____Home Phone Number_____
(PT Initials)

_____Work Phone Number _____
(PT Initials)

_____Cell Phone Number_____
(PT Initials)

_____ Emergency Contacts Number_____
(PT Initials)

Please read below and consider carefully who you want to have access to your medical information. Unless we have your written permission to do so, **we will not.**

I give permission for **Kirkwood Medical Associates** to discuss anything regarding my medical care with the following person (s):

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP:_____

NAME: _____RELATIONSHIP:_____

_____ _____ _____
Patient Name (Print) **Patient Signature** **Date**

HCA Physicians Services
OFMST
Ron Kirkwood, D.O, M.E. "Bo" Kirkwood, D.O, John Kirkwood, D.O,
Toby Kirkwood, D.O, Frank Ponce III, MD, Noah Smith, P.A, Lindsey Qualls, P.A.

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **The consent will remain in full force until revoked in writing**.

I understand that **Kirkwood Medical Associates** includes consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Kirkwood Medical Associates** will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to **Kirkwood Medical Associates** or benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized person to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the Public Health Department and appropriate counseling will be offered.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Kirkwood Medical Associates.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. .

_____ _____

Patient (or Responsible Party) Signature ***Date***

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Assignment of Benefits

I hereby assign to Kirkwood Medical Associates any insurance other third-party benefits available for health care services provided to me. I understand that Kirkwood Medical Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Kirkwood Medical Associates, I agree to forward to Kirkwood Medical Associates all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal
Guardian: _____

Date _____