CENTRO DE SALUD FAMILIAR LA FE, INC.
CONSENT FOR DIAGNOSIS AND TREATMENT

I, _____(Print) authorize Centro de Salud Familiar La Fe, Inc., healthcare providers
Print
and other clinical personnel to provide health care services to me and those minors listed on this Consent for Diagnosis and Treatment form for whom I have legal responsibility. The health care services may include, without limitation, routine physical and mental assessment, diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays, administration of medications; and procedures and treatment prescribed by the center's healthcare providers. The healthcare services may also include counseling. I voluntarily request and give permission for these services. I have read and understand what I am signing. I understand that there are no guarantees from these services. This Consent for Diagnosis and Treatment is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent.

The adults listed below may accompany minor family members listed on this Consent for Diagnosis and Treatment for services.

_____
Initials

_____	_____	_____
Relationship	Relationship	Relationship

RELEASE OF INFORMATION AND PAYMENT REQUEST

I authorize any holder of medical or other information about me to release information needed by Medicare, Medicaid, Managed Care Plans, and/or Private Insurance or its intermediaries or carriers to process claims. I request that payment of authorized benefits be made on my behalf.

_____
Initials

COLLECTIONS FOR MEDICAID, MEDICARE, MANAGED CARE PLANS AND PRIVATE INSURANCE

I understand that the services that have been requested to be provided to me while I am a Medicaid, Medicare, Managed Care Plan or Private Insurance recipient may not be considered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care and/or are not benefits of the Medicaid Program, Medicare Program, Managed Care Plans, or Private Insurance. I understand that the State of Texas or the Federal Department of Human Services or its health insuring agents determine the medical necessity of the services that I request and receive.

I also understand that I am responsible for payment for the services I or family members for which I am legally responsible for request and receive, if these services are determined not to be reasonable or medically necessary for our care and/or are not benefits of the Medical Program, the Medicare Program, Managed Care Plans, and Private Insurance Agency.

_____
Initials

REGISTRATION

I certify that all information provided during registration is true and correct. I will pay the co-payment or percentage assigned at the time services are rendered. If I cannot comply with the aforementioned, services will be suspended, except in emergency cases.

_____
Initials

PATIENT AND CENTER RIGHTS AND RESPONSIBILITIES
NOTICE OF CLIENT PRIVACY RIGHTS

I acknowledge having received a copy of the patient and Center Rights and Responsibilities and the Notice of Client Privacy Rights.

_____
Initials

_____	_____	_____
Head of Household Signature	Account Number	Date
_____	_____	_____
Spouse Signature	Account Number	Date
_____		_____
Centro de Salud Familiar La Fe, Inc., Employee		Date

Minor Family Members for whom I_____ have legal responsibility:
Print

_____	_____
Name	Account Number
_____	_____
Name	Account Number
_____	_____
Name	Account Number
_____	_____
Name	Account Number
_____	_____
Name	Account Number