CONSENT FOR OUTPATIENT TREATMENT AND AUTHORIZATION FORM

1. I hereby authorize Bronx Health Center, the physicians, dentists and other health care professionals to provide such medical care and to administer such treatment, including immunizations as deemed necessary or advisable to me or the named patient each time I or the named patient present to an ambulatory care service. To the extent possible I have been informed of risks and complications that may occur and alternatives that may be available.

2. I acknowledge that no guarantees or assurances have been made to me concerning the results intended from my treatment.

Medicare patients

3. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Guarantee of account

4. For and in consideration of service rendered to (name) _____by Bronx Health Center hereby agree to pay the full bill for all charges which are not covered by or paid in full by my medical insurance.

Release of information

5. I permit Bronx Health Center to disclose all or a part of the above patient's medical record to any person, corporation, or agency when required for the collection of benefits or payment of Bronx Health Center charges.

Assignment of benefits

6. I assign to Bronx Health Center all benefits from any corporation, agencies and person for these services. Additionally, I authorize payments of these benefits directly to Bronx Health Center.

7. I confirm that I have read and fully understood the above.

_____	_____	_____
Name of Patient/Relative or Guardian	Signature of Patient/Relative or Guardian	Date

Relationship (if signed by person other than patient) _____

_____	_____	_____
Name of Interpreter (If required)	Signature of Interpreter	Date

_____	_____	_____
Name of Witness	Signature of Witness	Date

The signature of the patient must be obtained unless the patient is unemancipated minor under the age 18 or is otherwise incompetent to sign.

This is to confirm that I am not able to pay the difference in the payment, which is not covered by the insurance.

Signature _____