Trinity Doctors Group, P.A., 8133 State Road 54, New Port Richey, FL 34655

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- 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 diagnostic 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, the undersigned, acknowledge that Trinity Doctors Group will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices, which I received. A photocopy of this consent shall be considered as valid as the original.

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 Trinity Doctors Group.
I acknowledge that I have been given the Trinity Doctors Group Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.
Patient Initial:_____

I also, agree to **pay at the time of service**. I will be responsible for a $25.00 fee for returned checks. I agree that I will give 24 hours notice for cancellation of an appointment, *as per the cancellation policy*. I understand that Trinity Doctors Group reserves the right to discontinue services if two or more appointments have been missed. If I am more than 15 minutes late past my scheduled appointment, it may be considered a missed appointment at that time. Please refer to the appointment cancellation policy for more details.

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