



CAROLINA MEDICAL AFFILIATES  
 NORTH GROVE MEDICAL PARK  
 1330 BOILING SPRINGS ROAD  
 SUITE 2500  
 SPARTANBURG, SC 29303

**GENERAL CONSENT TO TREAT/  
 PATIENT AUTHORIZATION/ACKNOWLEDGEMENT OF BENEFITS RELEASE**

The following are the conditions for services provided by Carolina Medical Affiliates for the patient whose name appears at the bottom of this page.

**CONSENT FOR MEDICAL TREATMENT**

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Carolina Medical Affiliates and its associated physicians, clinicians, and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

**ASSIGNMENT OF INSURANCE BENEFITS**

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Carolina Medical Affiliates. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand Carolina Medical Affiliates can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

**WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION FORM**

I understand that South Carolina and North Carolina Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the SC Code Ann § 42-15-95 and NC ST § 97-27. **I authorize Carolina Medical Affiliates to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

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Date and Time

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Signature of Patient/(Relationship to Patient)  
 (Parent, Guardian, or Legally Authorized Representative)

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Witness

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Signature of Guarantor (Relationship to Patient)