VIBRANCE INTERNAL MEDICINE

Greenville, NC

CONSENT FOR TREATMENT

I consent to the Medical treatment deemed necessary by the health care provider(s) of *Vibrance Internal Medicine* upon my presentation.

I consent to the disclosure of any information to outside providers or agencies involved in my treatment as deemed necessary by my *Vibrance Internal Medicine* provider(s), or if such disclosures are required or permitted by law.

I consent for *Vibrance Internal Medicine* to release any information required in the course of my examinations and treatments for the purposes of insurance and/or Medicare benefits payment. Workman's Compensation claim information may be released to my employer.

I consent to assignment of payment directly to *Vibrance Internal Medicine* of all medical benefits applicable and otherwise payable to me through insurance or any other source.

I agree, in consideration of the services being rendered to me, I am hereby individually obligated to pay my account with *Vibrance Internal Medicine* in accordance with its regular rates and terms. If, signing as a representative, a parent or guardian, or otherwise legally responsible person for the patient, I agree to the obligation described herein.

I consent to the disclosure of my medical information to people outside of *Vibrance Internal Medicine* involved in any clinic operations or if such disclosures are required or permitted by law.

I consent for *Vibrance Internal Medicine* to communicate with me regarding my scheduled appointments through any media available. Additionally, Vibrance may use or disclose information about me to notify or assist in notifying a family member, personal representative, or another person responsible for my care, of my location and general condition. Vibrance may also contact me with information about treatment alternatives or other health related benefits and services of interest to me.

I consent for *Vibrance Internal Medicine* to communicate with a family member or other relative, close personal friend, or any other person I identify, my health information relevant to my care or payment related to my care.

Signature ______________________________ Date ______________

I hereby acknowledge the receipt of a copy of the Vibrance Internal Medicine Notice of Privacy Practices.

Signature ______________________________ Date ______________