

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

INITIATION OF SERVICES

PART I CLIENT - PROVIDER RELATIONSHIP CONSENT

Client Name: _____

Name of Agency: Volusia County Health Department Dental Clinic

Agency Address: 1845 Holsonback Dr., Daytona Beach, FL 32117

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSENT (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART III MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART IV ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

Client/Representative Signature

Self or Representative's Relationship to Client

Date

Witness (optional)

Date

PART VI WITHDRAWAL OF CONSENT

I, _____
Client/Representative Signature

WITHDRAW THIS CONSENT, effective _____
Date

Witness (optional)

Date

Client Name: _____

ID#: _____

DH 3204, [Approved November 2008],

Original to file Copy to client

DOB: _____