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

Florida HEALTH Volusia County

Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

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, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature Date

_____ _____
Witness (optional) Date

Client Name: _____
ID#: _____
DH 3204, [Approved November 2008], Original to file Copy to client DOB: _____

Florida Department of Health
in Volusia County • Dental Office
1845 Holsonback Dr., • Daytona Beach, FL 32117-5114
PHONE: 386-274-0895 • FAX: 386-274-0894
Volusia.FloridaHealth.gov

PHAB Accredited Health Department
Public Health Accreditation Board