# Initiation of Services

Part 1 CLIENT-PROVIDER RELATIONSHIP CONSENT
Client Name: _____
Name of Agency:____Pasco County Health Department_____
Agency Address:____10841 Little Road New Port Richey FL 32654
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 rountine 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 MIDICARE PATIENT CERTIFICATION,AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Oonly applies to Medicare Clients) As client/Representative signed below, I certify that the information given by me in apply 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 the 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 V 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 agreement.
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

**DISTRICT SCHOOL BOARD OF PASCO COUNTY**
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

## HOLD HARMLESS, INDEMNIFICATION, AND RELEASE AGREEMENT

This agreement is a waiver, release, indemnification agreement, and hold harmless, which acts to release the District School Board of Pasco County, its individual members, schools, personnel, employees, agents and assigns (hereinafter collectively referred to as School Board) from any and all judgments, attorney fees, costs, payments, medical bills, damages, claims, suits or other expenses which may result from the use of School Board property by The Florida Department of Health in Pasco County, (hereinafter PasCHD) for the purposes of providing dental health services. Parent/guardian agrees to release and hold the School Board harmless for any injuries, damages, suits or claims, arising out of this matter, regardless of whether such injuries or damages arise out of the accidental, negligent or reckless acts of PasCHD or School Board, its employees, subcontractors, agents and assigns. Parent/guardian understands that, for the purposes of this agreement, participation in the event, and the protections afforded to the School Board by this agreement, not only extends to and includes the service provided but also encompasses any other acts while on School Board property that are directly or indirectly related to the evet.

**Parent/Guardian Signature** **Date**