PATIENT CONSENT AND ACKNOWLEDGEMENT

CONSENT FOR EVALUATION AND TREATMENT

I hereby consent to and authorize Priority One Drug Testing, LLC, its affiliates, physicians, employees (PODT) to perform a physical examination and/or medical treatment deemed necessary. Treatment may include, without limitation, any required examination, medical diagnostic or laboratory tests and medical procedures ordered by the physician(s) to be performed by the designated PODT staff. I understand I may refuse treatment at any time. If I am presenting to PODT for non-regulated substance abuse testing, I voluntarily consent to and authorize PODT to obtain a specimen of my urine, blood, saliva, breath, hair and/or other specimen, to determine the presence of drugs and/or alcohol. I understand that certain special medical exams such as physical exams (e.g. fitness for duty, school or sports) and other services are not intended to diagnose medical conditions, determine treatment needs, or replace the medical care of my personal physician.

CONSENT TO USE AND DISCLOSE INFORMATION/RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that PODT desires that I be fully informed about how my protected health information will be used and disclosed. I acknowledge that I have reviewed or have been given an opportunity to review the PODT Notice of Privacy Practices. I acknowledge that I understand how my information will be used and disclosed, and give my voluntary consent to PODT to use and disclose my protected health information for reasons as allowed or required as explained in the Notice.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY AGREEMENT

- If applicable, where I am treated on a private pay basis I understand I am responsible for payment services in full. I have a right to ask for the charge amounts before electing payment.
- If applicable, for employer directed or required services (e.g. drug testing, physicals, medical surveillance) PODT will seek payment from the employer. Individual patients may be responsible for payment only as allowed by State or Federal law.
- Should my account be referred for collection, I understand that I may have to pay collection expenses incurred by PODT, without limitation, court costs and attorney's fees as allowed by law.

By signing this form I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

Patient Signature: _____ Date: _____

Patient Name: _____ Date: _____