Consent for Treatment

Your consent is **effective** for **1 year**.
This document must be

Initialed .......... J D

And

Signed .......... John Doe

to be a legal document
Your J D mean initials

You understand ..........

and

You agree ..........
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The **Notice of Privacy Practices** describes your **rights** as a **patient**.

Did you receive a **Notice of Privacy Practices**?

- [ ] Yes
- [X] No

___

Initials
Consent for Treatment

☐ I agree to care at (Hospital).

Treatment may include:

- Immunizations
- Lab testing
- Other medical services

My care team may include:

- Residents
- Students
- Trainees

(Hospital) cannot guarantee the results of:

- Treatments
- Surgery
Consent for Release of Information

(Hospital) can release information about:

- Me
- My health
- Health services for me
- Payment

(Hospital) can release information for:

- Treatment
- Payment
- Health care operations

(Hospital) can take pictures and videos for health care purposes.
Consent for Release of Information

(Hospital) *can release* my *financial* and *payment information* to:

Person: ______________________

Relationship to Patient: ______________________

__________________________
Initials
Services will be billed separately from hospital charges.

Actual charges may differ from charge estimates given to me.

If insurance does not pay the full amount of my charges, I am responsible for the remainder.

If I do not have insurance, I am responsible for paying all charges.

Overpayment will be used to pay any unpaid charges.
I will only **pay for services** that are considered **reasonable** by Section 1862 (a)(1) of the Medicare Law.

I certify that the **information** I give for **payment** is **correct**.

I ask that **payment** be made to the **appropriate branch** of Hospital.

(Hospital) may **bill all charges** not paid by insurance directly to **me**.
I gave my social security number freely.

(Hospital) may use my social security number for:

- Accurate identification
- Filing insurance claims
- Billing and collections
- Compliance with laws
(Hospital) may **contact** me by **telephone** and pre-recorded voice messages.

**Personal Property**

I do **not** hold (Hospital) **responsible** for any **theft** of, or **damage** to, my personal **items**.
Can (Hospital) give this information to people who ask for you?

- Your Location in the building
- Your general condition

Yes

No

Initials
Can **Hospital** give this **information** to the community **clergy**?

- Your **Location** in the building
- Your general **condition**
- Your **religious affiliation**

[Check] Yes [X] No

[Initials]
Can your **personal health information** be **shared** with **family** and **friends**?

- [ ] Yes
- [ ] No

**Initials**
• I understand that I can withdraw this consent in writing.
• I received a copy of this form.

Please check only one box. I am:

☐ The patient
☐ Allowed to act on behalf of the patient

Signature: _____________ Date: __/__/__
Printed Name: _____________
Relationship (if not patient): _____________
Witness: _____________ Date: __/__/__

Guarantor: I agree to pay all charges, even if I am otherwise not legally obligated to pay.

Signature: _____________ Date: __/__/__
Printed Name: _____________
Witness: _____________ Date: __/__/__