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 *JD* 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

☐

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) **<u>cannot</u> 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

Financial Responsibility

☐ **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**.

Medicare/Medicaid/Insurance

☐ 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**.

Social Security Number

☐ 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

Telephone Number

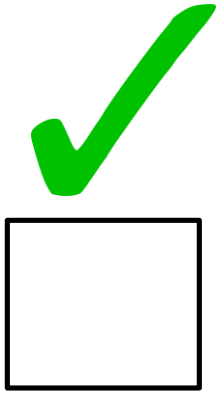
☐ (Hospital) may **contact** me by **telephone** and pre-recorded voice **messages**.

Personal Property

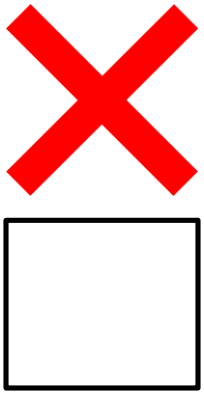
☐ I **do <u>not</u> hold (Hospital) responsible** for any **theft** of, or **damage** to, my personal **items**.

Can **(Hospital)** give this **information** to **people** who ask for you?

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



Yes



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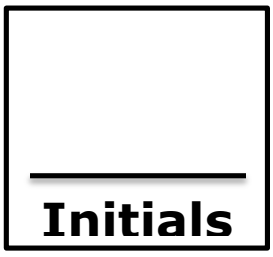
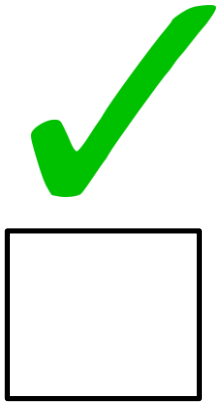
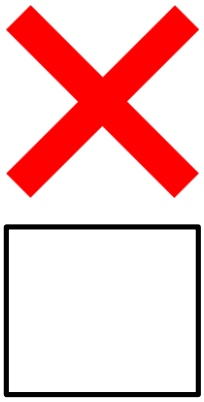


Can **(Hospital)** give this **information** to the community **clergy**?

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



Yes



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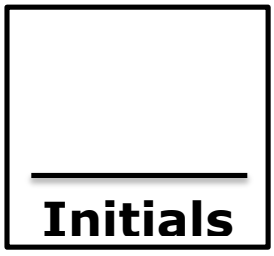

Initials

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: __ /__ /__