## Consent for Treatment & Release of Health Information

NAME OF PATIENT: _____ DATE: _____/_____/_____

1. **CONSENT FOR TREATMENT:** I request and voluntarily consent to the usual medical services as a patient at Access Family Health Services, Inc. (here on referred to as "AFHSI" or "the clinic"), as well as the diagnostic laboratory (testing of the blood and other bodily fluids) and x-ray procedures (including intravenous injection of contrast material) and medical treatment, including administration of anesthesia and other treatment as deemed necessary by my physician, his assistants or other designated physicians. The clinic is authorized to retain, preserve, and use for scientific or teaching purposes, or dispose of, at its convenience, any specimens or tissue removed from my body during treatment.

2. **MEDICAL CARE:** During treatment at the clinic, I (the patient), will be under the professional care of a physician. I understand that no guarantees have been made as a result of examination or treatment while in the clinic.

3. **COMPLIANCE WITH RULES & REGULATIONS:** In consideration of treatment, I agree to abide by the rules of the clinic, including no smoking.

4. **PERSONAL VALUABLES:** I agree that the clinic will not be liable for the *loss of* or *damage to* any personal property that I may bring to the clinic.

5. **RELEASE & RESPONSIBILITY:** I hereby agree, acknowledge, and understand that the clinic is not responsible for injuries sustained by use of my own personal equipment – electrical, mechanical, or otherwise. I further understand and agree that if I should leave the clinic without the consent of my physician (against medical advice), I hereby relieve my physician and the clinic of all responsibility for such action.

6. **CONSENT TO DESTROY X-RAY & RADIOGRAPHIC DATA:** I hereby authorize the clinic to retire or destroy my x-ray images (film and/or digital), and any other radiographic data, four (4) years after generation, if a proper report is in the medical record.

7. **ASSIGNMENT OF BENEFITS:** As the patient or patient's representative, I make the following assignment of benefits:

   **MEDICARE and/or MEDICAID** • I hereby request that payment of authorized Medicare and/or Medicaid benefits to or on my behalf for services rendered in or by the clinic, shall be made to the clinic, and I specifically assign such benefits to the clinic. I hereby certify that all information I provide, in connection with applying for benefits under Title XVIII of the Social Security Act, is true, correct, and complete in all respects. **I understand that payment for services deemed not medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid program, and I may be responsible for the incurred charge(s), unless other third-party coverage is available.**

   **INSURANCE** • I hereby assign to the clinic all rights, benefits, and interest under any insurance policy, health plan, workers' compensation, or other third-party payer liable to me, in consideration for services rendered by the clinic. I hereby authorize payment directly to the clinic by any insurance policy, health plan, or third-party payer for treatment received at or by the clinic. I hereby authorize payment of workers' compensation coverage directly to the clinic for expenses incurred at the clinic. I hereby authorize payment directly to the clinic of all third-party liability insurance coverage, third-party payer, health plan, and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury, or illness for which I received treatment at the clinic.
   I understand that I am responsible for ensuring that all claims are submitted to my insurance company, the submission of my insurance claims by the clinic is only as a courtesy, and there is no guarantee that all claims are properly submitted.

8. **FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible to the clinic for all charges not paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan, or other third-party payers are due and payable upon services rendered based on the best estimates available as determined by the clinic. Charges remaining on this account which are not paid by insurance, health plan, or other third-party payer, are payable upon demand. I also agree that if this account is assigned to a collection agency or attorney for collection or suit, all collection fees, attorney fees, cost, and other expenses will be paid by me. I also understand, agree, and authorize the clinic to verify employment status for the purpose of processing my clinic bill for payment.

9. **COMMUNICATION:** I authorize all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me using pre-recorded messages, artificial voice messages, automatic telephone dialing devices/services, or other computer-assisted technology, and/or by email, text messaging, or any other form of communication.

10. **NON-CERTIFICATION OF OUTPATIENT PROCEDURES:** I hereby agree that as the policyholder/beneficiary of insurance, health plan, or other third-party payer, I am responsible for assuring certification is obtained from the insurance company, third-party administrator, or health plan for the treatment provided. If certification is not obtained, I further agree that in the event the insurance, health plan, or other third-party payer denies all or part of the payment on services rendered, the clinic will not be liable.

11. **CONSENT FOR THE RELEASE OF HEALTH INFORMATION FOR BILLING & PAYMENT PURPOSES:** I hereby consent to the release of my health information (medical records, medical results, and all other health information) by clinic or any physician involved in my care for the purpose of: billing; claims management; medical data processing; eligibility documentation; reimbursement; and certification to any insurance company, third-party payer, health plan, or government agency which is necessary for the billing and payment of my account.

12. **FINANCIAL ASSISTANCE** (SLIDING FEE PROGRAM)**:** I understand that if I am uninsured or underinsured, financial assistance may be available. If I need assistance I can contact the clinic's sliding fee coordinator for further information about financial assistance for uninsured or underinsured patients. **I understand that sliding fee/financial assistance will be denied if I fail to truthfully and timely provide information to verify my eligibility.** I understand that my application for financial assistance/sliding fee expires one (1) year from the date of the original application, and to continue receiving financial support I must reapply if my application has expired.

13. **NOTICE OF PRIVACY PRACTICES:**
*Access Family Health Services, Inc. uses SureScripts and Allscripts to electronically exchange data regarding prescriptions and related information between my providers and pharmacies. The information sent between these systems may include details of prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by Access Family Health Services, Inc. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts and Allscripts to Access Family Health Services, Inc.*

By signing below, I acknowledge that I have been informed of and/or received the *AFHSI Notice of Privacy Practices*. My acknowledgement does not mean I agree with or I have read the Notice of Privacy Practices.

14. **DISCLOSURE OF PERSONAL HEALTH INFORMATION:** Access Family Health Services, Inc. will not, without your authorization, discuss your personal health information with anyone except those allowed under Federal and State law or those listed below.

**List the names and relationships of those you authorize us to discuss your personal health information.**

| Contact Name (please **print**) | Relationship (please **print**) | Contact Number |
|---|---|---|
| | | – – |
| Contact Name (please **print**) | Relationship (please **print**) | Contact Number |
| | | – – |
| Contact Name (please **print**) | Relationship (please **print**) | Contact Number |
| | | – – |

**I, the undersigned, as the patient or patient's legal representative, have read this entire document, understand the content, and agree to the terms.**

_____ ____/____/____

Signature of Patient **or** Patient's Representative Date

_____ _____

**If Authorized Person signed above**, what is your relationship to the patient? Clinic Witness