PHYSICIAN CLINIC TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

This treatment authorization will be renewed on an annual basis.

1. **CONSENT FOR TREATMENT:** I consent laboratory procedures, anesthesia, medical treatment, surgical treatment, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I also consent to the presence of other medical and paramedical personnel, which may include medical and paramedical personnel participating in training programs through the Hospital's partnership with area training programs (for example, residents, nurses, APPs) during the delivery of services. I understand that my treatment is under the control of my attending physicians, their assistants or designees. I understand that I will be asked to provide specific consent for certain diagnostic studies or other treatment procedures. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services. I understand that any licensed medical personnel involved in the delivery of services will act within the scope of the licensure.
2. **CONSENT FOR BLOOD/BODY FLUID TESTING:** I consent to have the Clinic determine by laboratory testing whether or not my blood contains contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health, the health of my family, or the health care personnel or emergency response person(s) who may have been exposed to my blood or bodily fluids.
3. **CONSENT FOR PHOTOGRAPHY, AUDIO, VIDEO RECORDING:** I agree that medical images, photographs, audio recording, digital recording or video recording may be made while I am receiving treatment in the Clinic. I understand that the images and audio from such photography and recording may be used for my treatment. If made, photographs, audio recording, digital recording and video recording will be included in your health record.
4. **AGREEMENT TO PAY FOR SERVICES:** I agree, that in consideration of services to be rendered to me or to the patient for whom I am signing this authorization, I hereby obligate myself to pay the charges of the Clinic in accordance with its regular rates and terms.
5. **CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS:** I agree that the Clinic may utilize, destroy or dispose of any tissues, fluids or specimens taken from me during treatment.
6. **ASSIGNMENT OF ISSURANCE BENEFITS:** I hereby assign insurance benefits otherwise payable to me directly to the Clinic. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered by third-party payers. If I do not pay the amount due as I

agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

7. **MEDICARE/MEDICAID BENEFITS:** I authorize the Clinic to release to Medicare and/or Medicaid, to Social Security Administration and/or its intermediaries or carriers and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the Clinic for services furnished to me.

8. **REPORTING CERTAIN DISEASES:** Certain diseases and conditions, including cancer, are required by law to be reported. I understand that the Clinic will comply with its legal reporting obligations by submitting the necessary information to the proper authorities.
9. **PROVIDER NON-DISCRIMINATION ACT:** I understand that the Clinic is an equal opportunity institution and will not discriminate because of race, color, religion, natural origin, age, sex sexual orientation or handicap.
10. **CONTRABAND WEAPONS/DRUGS:** I agree that should the Clinic find contraband weapons, nonprescription drugs that are not sold over-the-counter, or any other type of contraband with my possessions, on or near my person or in my room, these items will be confiscated and the police will be contacted.
11. **NOTICE:** Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.
12. **ADVANCE DIRECTIVE INFORMATION:** (complete for all patients) **YES** **NO**

Do you have a living will?	
Do you have a Medical Durable Power of Attorney (DPOA)?	
If yes, is the living will or DPOA on file?	

13. **CONSENT FOR CONTACT BY LANDLINE OR CELLULAR TELEPHONE NUMBER:** I hereby consent to Clinic, or its agents or representatives, contacting me by the follow means (even if the Clinic, or its agents or representatives, initiate contact using an automated telephone dialing system (ATDS) and/or an artificial or prerecorded voice); (1) paging system; (2) cellular telephone service; (3) landline; (4) text message; (5) email message; or (6) facsimile.
14. **PRESCRIPTION HISTORY CONSENT:** I agree that the Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

15. **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I hereby acknowledge that there is a copy of the Clinic's Notice of Privacy Practices available to me so that I may take it with me.

I certify that I have read and fully understand this document. I understand that a copy of this document is available to me. I, individually, or as the patient's personal representative, by signing this document agree that I agree with all of its content.

_____ _____ _____

Patient or Personal Representative **Relationship to Patient** **Date**

_____ _____

Witness Signature **Date**