



CONSENT TO MEDICAL CARE AND PATIENT SERVICES AGREEMENT

Patient Name _____

Primary Care Physician: _____

1. **Consent to Medical Care:** I consent to and authorize the providers at Saint Alphonsus Medical Group to furnish to the Patient necessary medical care, including diagnostic tests, lab tests, x-rays, medications, supplies and any medical or surgical procedures, the Patient's physician deems necessary or advisable for the Patient's health or well-being. I understand that all such medical care involves some degree of risk and that there are no guarantees as to the results of such care and treatment. I understand that I have the right to consent to or refuse consent to any proposed medical care and no substantial medical procedure will be performed without my informed consent as required by law.

2. **Acknowledgment of Notice of Privacy Practices:** I have been offered the Saint Alphonsus Medical Group Notice of Privacy Practices (Version 101509.1) that provides information about how Saint Alphonsus may use and disclose protected health information (PHI) for purposes of treatment, payment and health care operations. Please initial _____

3. **Release of Drug and Alcohol and Drug Records:** I DO specifically consent to and authorize the Medical Center to release records of alcohol and drug abuse treatment protected under Section 333 of the comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1980 and Section 408 of the Drug Abuse Office and Treatment Act of 1972 to any health care provider for continuing medical care and to any party, person, or entity responsible for payment and processing of charges relating to my medical care unless I check and initial the following: I DO NOT consent. Please initial_____.

4. **Financial Policy:** I have been provided a copy of the Financial Policy relating to medical care by the Saint Alphonsus Medical Group and agree to read and abide by it. Please initial _____

5. **Medicare Patient Assignment of Benefits:** I request that payment of authorized Medicare benefits be made either to me, or on my behalf, to Saint Alphonsus Regional Medical Center or Saint Alphonsus Specialty Services, Inc. for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

6. **Medicare/Medigap Authorization:** I request that payment of authorized Medigap benefits be made on my behalf to Saint Alphonsus Regional Medical Center or Saint Alphonsus Specialty Services, Inc. for services furnished to me by their providers. I authorize the holder of medical information about me to release to my Medigap insurer any information required to determine these benefits payable for related services.

Place Patient Sticker here or handwrite

Name: _____

DOB: _____

CONSENT TO MEDICAL CARE AND PATIENT SERVICES AGREEMENT (continued)

7. Insurance Authorization and Assignment of Benefits: I consent to and authorize Saint Alphonsus Regional Medical Center or Saint Alphonsus Specialty Services, Inc. to furnish medical information to any third party who may be responsible for payment of all or part of my charge incurred today. I authorize my insurance company, or any responsible third party to pay benefits directly to Saint Alphonsus Regional Medical Center or Saint Alphonsus Specialty Services, Inc. and I will pay for any charges not covered by insurance. I will pay any legal fees incurred by the Medical Center in collecting this account.

8. Health Care Rights: I have received information regarding patient health care rights, including the right to make Advance Directives.

This form has been explained to me and I certify that I have read it, understand its contents, have had an opportunity to have my questions answered and I voluntarily agree to its provisions. By signing this form I hereby consent to medical care by Saint Alphonsus. This consent shall remain valid for a period of one (1) year from today's date unless revoked by me in writing prior to that time.

Patient's Signature

Date and Time

Witness

The Patient is unable to sign because _____,

I therefore sign and consent to medical care for the Patient and agree to the other provisions of this form as the Patient's authorized legal representative.

Legal Representative's Signature/Relationship to Patient

Date and Time

Witness

Place Patient Sticker here or handwrite

Name: _____

DOB: _____