

Blue River Family Medicine

PHYSICIAN CLINIC TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

Patient Name: _____ Date of Birth: _____

Medical Record No.: _____ Visit No. _____ Admission Date: _____

This treatment authorization will be renewed on an annual basis.

- 1. CONSENT FOR TREATMENT:** I consent to radiographic and ultrasound examinations, laboratory procedures, anesthesia, medical treatment, surgical treatment, clinic services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. 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, surgeries 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.
- 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 of any health care personnel or emergency response person(s) who may have been exposed to my blood or bodily fluids.
- 3. 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.
- 4. CONSENT FOR PHOTOGRAPHY, AUDIO, VIDEO RECORDING.** I understand that medical images, photographs, audio recording, digital recording or video recording may be made while I am receiving treatment in the Hospital/Clinic and that these images or recordings will become part of my health information subject to uses and disclosures as described in the Notice of Privacy Practices. I consent to the taking or recording of such images and/or audio.
- 5. 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. I also understand that services may be provided by individuals who are not employed by the Clinic who will bill me separately for their services.
- 6. ASSIGNMENT OF INSURANCE 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 the 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, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Clinic.

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 Hospital/Clinic is an equal opportunity institution and will not discriminate because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.
10. **NOTICE:** Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.
11. **PERSONAL VALUABLES/BELONGINGS:** I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Clinic CANNOT AND WILL NOT accept responsibility for loss of any of my valuables/belongings, if they are lost or misplaced. (Dentures, glasses, hearing aids, my garments and essential daily necessities are considered personal belongings.)
12. **CONTRABAND WEAPONS/DRUGS:** I agree that should the Clinic find contraband weapons (including a gun without a concealed carry permit, or carried in a facility that is not covered by the law or has obtained an exemption), illegal drugs, and/or prescription drugs for which there is not a valid prescription, nonprescription drugs not sold over-the-counter within my possession, 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.
13. **KANSAS IMMUNIZATION REGISTRY:** I consent to inclusion of all immunization data in the Kansas Immunization Registry for the patient named above.
14. **PHARMACY:** I grant permission to the clinic to access my prescription medications through the electronic medical record.
15. **ADVANCE DIRECTIVE INFORMATION:** (complete for all patients including outpatients)

	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?		
If no, were you given Advanced Directive Education Material?		

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

16. **CONSENT TO DISCLOSE GENERAL INFORMATION.** I understand that my name, location in Clinic, and general condition may be provided to any person asking about me by name, and to members of the clergy, my family, individuals involved in my health care, for disaster relief efforts, or as required by law.

I do _____ do not _____ give consent for this information to be disclosed.

(Patient/Personal Representative Signature or Initial)

17. **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.

(Patient/Personal Representative Signature or Initial)

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

Patient/Personal Representative Relationship to Patient Date/Time

Signature, Witness Date/Time