BLUE RIVER
Family Medicine

PHYSICIAN CLINIC TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

Patient Name: _____ Date of Birth: _____

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. COLLECTIONS: I understand that any bill left to patient responsibility without payment or payment arrangements after 180 days will be sent to a collections agency. Upon balance transfer, patient will receive termination of patient services with a 30 day notification.

9. 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.

10. NO SHOW POLICY: All appointments require 24 hour cancellation notice, or may be subject to no-show fees according to appointment times allotted. 3 no-shows within a year will result in dismissal from the practice.

11. 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.

12. NOTICE: Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

13. 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.)

14. 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.

15. KANSAS IMMUNIZATION REGISTRY: I consent to inclusion of all immunization data in the Kansas Immunization Registry for the patient named above.

16. KANSAS HEALTH INFORMATION EXCHANGE: I understand that this office participates with KHIN and my records will be available to other participating healthcare organizations who may provide healthcare services to the patient named above. I understand it is my responsibility to notify KHIN if I wish to be excluded from the listing.

17. PHARMACY: I grant permission to the clinic to access my prescription medications through the electronic medical record.

16. ADVANCE DIRECTIVE INFORMATION: All patients are encouraged to provide a copy of their living will, medical durable power of attorney, or any other advance directives as part of their medical record. If you wish to receive further information regarding advance directives, education material is available upon request.

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

18. 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.

19. DISCLOSURE OF OWNERSHIP: Blue River Family Medicine is an affiliate of Manhattan Surgical Hospital, LLC, a physician owned and operated for-profit hospital. A list of physicians who have a financial interest in the hospital is available upon request. You are free to choose another facility in which to receive services.

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/Legal Guardian **Relationship to Patient** **Date/Time**

_____ _____

Signature, Witness **Date/Time**