

Consent for Treatment At Jefferson County Health Center

Patient Name:
Date of Birth:
MRN:
Date:

1. Consent to Health Services: I, (the patient or surrogate decision maker or financial guarantor on behalf of the patient) am presenting myself for treatment to the Jefferson County Health Center (hereinafter "Health Center") and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment, by authorized agents and employees of the Health Center, and by its medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial. I understand that my provider may not be an employee of the Health Center but may be an independent contractor or medical staff member who has been contracted to provide services and/or granted privileges to perform services at the Health Center. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition. I realize that during the course of my care at the Jefferson County Health Center, or for follow-up care, it may be necessary for the Health Center or my attending provider to make available to other health care providers information concerning my treatment, including but not limited to, copies of my medical records for information relating to my care, and I consent to such release.

2. Patients' Rights & Responsibilities: I acknowledge that the Patients' Rights & Responsibilities was made available to me and I understand my rights pertaining to; • Medical Care • Decision Making • Personal Needs • Discharge Planning • Visitation • Problem Resolution (complaints/grievances) • Confidentiality • Medical Records/Billing Statements

3. Personal Valuables: It is understood and agreed that the Health Center maintains a safe for the safekeeping of money and valuables and the Health Center shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, furs, other articles, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the Health Center for safekeeping. I understand that I may not bring on to Health Center premises for safekeeping any illegal drugs, toxic substances, weapons, alcoholic beverages, or dangerous articles.

4. Video/Photograph/Telemedicine: I understand that in connection with the Health Center registration and treatment policies and procedures (including, but not limited to telemedicine procedures), the Health Center may videotape, photograph, or otherwise record the care it provides me. I hereby consent to such video/photograph/telemedicine recordings by the Health Center.

5. Assignment of Insurance Benefits: In the event I am entitled to health care benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to the Health Center for application on patient's bill. I will be responsible for charges not covered by this agreement. I understand that it may be necessary for the Health Center to release copies of my medical records to my insurance company to determine payment eligibility. I consent to the release of these medical records for this purpose.

6. Financial Agreement and Payment Guarantee: I agree that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the charges of the Health Center in accordance with the regular rates and terms of the Health Center. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

7. For Medicare/Medicaid Beneficiaries Only: I certify that the information given by me in the applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished my by, or in, Jefferson County Health Center, including providers services. I authorize any holder of medical or other information about me to release to the Centers of Medicare/Medicaid Services (CMS) and agents any information necessary to determine these benefits or related services.

I certify that I have read the foregoing, and am the patient, or am duly authorized by the patient as patient's general agent to execute the above and accept its terms. All guarantors certify that they have read the foregoing and accept its terms. I understand that I may revoke the authorization at any time, except to the extent that action has already been taken in reliance upon in it, by giving written notice to the Health Center.

Patient/Representative Signature:

Jefferson County Health Center USE ONLY

Relationship:
Parent Consent to Treat on File:
Verbal Consent Collected:

Name:
Witness #1:
Notes:

Call Date/Time:
Witness #2: