PATIENT CONSENT AND AUTHORIZATION

1. CONSENT TO MEDICAL CARE AND TREATMENT

While at a Grant Riverside Medical Care Foundation office, I consent to all medical and surgical care, examinations and tests determined to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. If I refuse treatment that is suggested for me or do not complete any treatment protocol recommended to me, I will not hold Grant Riverside Medical Care Foundation or any individual responsible for any of the consequences.

2. **RELEASE OF INFORMATION**

I understand Grant Riverside Medical Care Foundation may use health information for a range of purposes including: insurance/payment eligibility verification, billing and collecting moneys due from me, private and public payors or their agents including insurance companies, managed care entities, my employer, state and federal government programs and the Bureau of Workers' Compensation; obtaining pre-admission or continued length of stay certification; quality of care assessment and improvement activities; evaluating the performance or qualifications of physicians and health care workers; conducting medical and nursing training and education programs; conducting or arranging for medical review and audit services; ensuring compliance with legal, regulatory and accreditation requirements, and; public health activities. I authorize Grant Riverside Medical Care Foundation to receive or release my health information, whether written, verbal, electronic including secured internet web sites, or by facsimile to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care.

I understand that complete, accurate health information must be readily available for my medical care. Therefore, I authorize Grant Riverside Medical Care Foundation to release health information to referring physicians or agency(ies) in order to facilitate continuity of care. I understand that the information shared with health care professionals as a result of this authorization will remain confidential.

The preceding authorizations for release of medical information include authorization for the release of information regarding drug and/or alcohol abuse, HIV (Human Immunodeficiency Virus) testing or HIV infection related conditions. This authorization shall remain valid for one (1) year.

3. **ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received or been offered a copy of Grant Riverside Medical Care Foundation's Notice of Privacy Practices and have had a chance to object to the use or disclosure of my information for disaster relief or to provide information to family or persons involved in my care.

4. ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of all insurance benefits to be made directly to Grant Riverside Medical Care Foundation for services provided to me. I understand that benefits could be paid directly to me if I did not provide this authorization.

5. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance benefits. I understand that charges due by the patient are to be paid within 30 days of receipt of a statement and that failure to pay a balance could result in referral to a collection agency and/or termination from the practice. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid or other insurance or payors. Services not eligible for benefits may include tests and procedures that are not covered, or those delivered by health care providers who do not participate with my insurance plan. Non-covered services may also include those my physician determines medically necessary, but are later determined unnecessary by my insurance plan. I understand that I will be responsible for payment of these services.

6. PERSONAL VALUABLES

I understand that Grant Riverside Medical Care Foundation does not accept responsibility for any lost, stolen or damaged personal items. I accept responsibility for those items I choose to keep with me while at Grant Riverside Medical Care Foundation offices.

By signing below I acknowledge that I have read these policies and have been given the opportunity to ask questions and receive clarification so that I fully understand and agree to abide by these policies:

NAME (PRINT)_____ SIGNATURE: _____

DATE: _____/_____/_____