



**GENERAL CONSENT FOR TREATMENT
MEDICAL PRACTICE NETWORK**

Patient's Name: _____ Medical Record Number: _____

1. **CONSENT:** I request and authorize Health Care as my physician, and his/her designees may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration.
2. **TEACHING INSTITUTION:** I have been informed that Providence Hospital and Medical Centers is a teaching institution and that my health care may be observed and provided for by supervised health care provider students. I understand that I will be asked at each visit if a student may participate in my care, and will be given the opportunity to refuse that participation.
3. **RELEASE OF INFORMATION:** I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Providence Hospital and Medical Centers to release all information from my medical record to:
 - 1) Payors, organizations or insurance companies which are responsible, in whole or in part, for obtaining insurance benefits for me, for billing and/or paying my hospital and/or physician(s) bill, and for filing appeals of denial of benefits, so that the hospital and physician may be paid for the services provided to me; and
 - 2) Independent auditors or review agencies retained by any third party payors and insurers to analyze the charges for services rendered to me.

In order to improve service and provide valuable input, I also authorize Providence Hospital and Medical Centers to release my demographic information to organizations retained by them for customer satisfaction surveys.

4. **VALUABLES:** I understand that Providence Hospital and Medical Centers is not responsible for valuables or personal articles.
5. **PAYMENT:** I assign and authorize payment, for any and all services rendered, directly to Providence Hospital and Medical Centers from my insurance company or third party payor including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and workers disability compensation insurance.

In consideration of the hospital and professional services provided or to be provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, copayments, noncovered services. I understand that it is my personal responsibility to pay Providence Hospital and Medical Centers all charges for services rendered despite of any disputes or disagreements between my insurance company and myself.

6. The Providence-St. John Health System Notice of Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS – related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this form. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the St John website at www.stjohn.org or by contacting the Privacy Officer listed in the notice.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the Providence-St. John Health Notice of Privacy Practices.

I have read the consent form or it has been read to me and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.

(Signature of Patient/Legal Guardian/Patient Advocate/Parent/Next of Kin-Circle One) (Date)