



Cornerstone Medical Group

Patient Name	_____
D.O.B.	_____
Patient Number	_____

GENERAL CONSENT TO OUTPATIENT TREATMENT CONSENT TO PHYSICIAN OFFICE, CLINIC, OR OUTPATIENT SERVICES

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostics procedures. I authorize the facility to dispose of these fluids and tissues.

I have been informed and understand that an HIV (human immunodeficiency virus - AIDS) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

TEACHING INSTITUTION

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The St. John Health Notice of Privacy 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 consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the St. John Health 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 St. John Health Notice of Privacy Practices.

Signature of Patient _____

Date _____

Time _____

Signature of Spouse _____

Date _____ **Time** _____

Signature of Witness _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative _____

Date _____ **Time** _____

Relationship _____

Address _____

Phone Number _____

Signature of Witness _____

I authorize any associate of Cornerstone Medical Group to disclose or release any of my Private Health Information to the following persons:

No one other than myself — I can be reached here: Phone Number (_____) _____

Spouse (Name) _____ Phone Number (_____) _____

Other (Name) _____ Phone Number (_____) _____

I authorize this office to call and confirm scheduled appointments one to two days in advance and to leave a message on home voicemail / recorder or with another family member.

I will provide written notice when I choose to revoke any of the above.

Signature _____ **Date** _____

Witness _____