Washington MEDICAL CENTER

Consent for Treatment, Assignment of Benefits and Release of Information

Patient Name		**Employer Name**	**MRN**
Mailing Address		Employer Address	**Responsible Party Name**
City / State / Zip		City / State / Zip	Relationship
Date of Birth		Employer Phone	Date of Birth
Patient SSN			SSN
Home Phone	Cell	**Emergency Contact**	Address
Email Address		Relationship	City / State / Zip
Sex Male ☐ Female ☐		Phone	Phone
Have you applied for Social Security Disability? ☐ Yes ☐ No		When?	Status of application: Approved ☐ Denied ☐ Pending ☐
I would like to consult with a pharmacist about the prescribed medication therapy.			**Yes** ☐ **No** ☐

Consent for Treatment

I authorize Washington Medical Center to administer infusion therapy in the outpatient clinic. My physician has instructed me on the prescribed therapy, and I understand why the medication is necessary, its risks, advantages, possible complications and alternatives. I also understand that in any medication therapy there are risks both known as well as unknown; I further understand that any complications, injuries or adverse results cannot be given the immediate medical attention in the outpatient clinic, as in the hospital setting. I have discussed these matters with my physician and my signature below indicates my willingness to undergo infusion therapy provided by Washington Medical Center. In the event of a staff blood exposure/needle stick, I agree to have my blood drawn.

Statement To Permit Payment Of Medicare Benefits To Provider

"I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services or its intermediary any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to Washington Medical Center as provider furnishing services".

Agreement to Pay

Washington Medical Services has agreed to supply patient with any supplies and services ordered by patient or on behalf of patient, the undersigned patient or responsible party agree that each of them is responsible for payment for all such supplies and services provided patient. Balances released to our attorney or collection agency for non-payment may incur additional fees, which will also be the responsibility of the patient or responsible party. Patient is responsible to pay co-pay/co-insurance at the time of service.

Assignment of Benefits

Assignment of Benefits The undersigned hereby authorizes Washington Medical Center to request on my/our behalf and to collect directly all public and private insurance coverage benefits or patient assistance funds due for supplies and services supplied by Washington Medical Center. In the event payments for insurance benefits or patient assistance funds are made directly to any of the undersigned, the payee will endorse to Washington Medical Center all checks for such payments.

Release of Information

The undersigned hereby authorizes our insurer(s) and any other third party payor who provides patient with coverage to disclose to Washington Medical Center any information regarding such coverage, including but not limited to 1) payments made by such insurer(s) or third party payor(s) to any of us, for infusion therapy rendered to patient by Washington Medical Center and 2) the scope and extent of coverage available from time to time. I also authorize all medical personnel to provide information to Washington Medical Center concerning patient/client medical history, as it may relate to patient/client therapy. The undersigned consents to the review of patient/client records including medical records by any Federal, State, or Accrediting Body or Agency as required by the Regulatory, Licensing or Accrediting body.

Notice of Privacy Practices

I acknowledge I have received the Washington Medical Center notice of privacy in full as contained in the patient information booklet. This booklet also contains the patient rights and responsibilities and I am responsible to read the information provided. The undersigned certifies that he/she has read the foregoing and received a copy, as well as a copy of the patient rights and responsibilities documented above. The undersigned also certifies that he/she is the patient or is duly authorized by the patient as patient's general agent to execute and accept its items.

Patient's Signature_____Date_____

Responsible Party's Signature_____ Date_____

If this form is not signed by patient, please explain. Reason: _____

Washington MEDICAL CENTER

PATIENT CONSENT

1. **CONSENT TO INFUSION THERAPY, MEDICAL CARE AND TREATMENT**

I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, and tests, provided by Washington Medical Center and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians"). I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinicians' recommendations as they may relate to my health that Washington Medical Center and the Clinicians will not be responsible for any injuries or damages that are the result of my non- compliance. I understand that if any employee or any individual associated with Washington Medical Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I **will** not be charged for testing and education related to the exposure.

2. **CONSENT TO TREATMENT IN AN OPEN TREATMENT AREA**

I acknowledge and understand that Washington Medical Center provides infusion therapy and medical care in an open treatment environment. Despite safeguards and using reasonable care, it is always possible in the infusion Center that I may learn information regarding other patients or they may inadvertently learn something about me. In all cases, Washington Medical Center expects and requires that its patients maintain strict confidentiality any inadvertently disclosed health information of others.

3. **CONSENT TO USE INFORMATION**

Electronic Health Records. I understand that the Washington Medical Center may collaborate with other health care providers to coordinate, manage, and provide health care to me, and I voluntarily consent to Washington Medical Center's sharing my health information and records electronically or otherwise for the purposes of treatment, payment, and operations and other purposes as outlined in the Infusion Center's Notice of Privacy Practices. I consent to the inclusion in my electronic health record of any sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. I understand that my electronic health records will be accessible by our Clinicians and other Infusion Center personnel and individuals approved to access such records for purposes related to treatment, payment, and health care operations and other purposes as outlined Washington Medical Centers Notice of Privacy Practices.

Use and Disclosure of Information.

In addition, I acknowledge and agree that Washington Medical Center may use and disclose my health information for a range of purposes, including but not limited to: treatment, eligibility verification, and payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work) state and government programs, Workers' Compensation programs, quality of care assessment and improvement activities, evaluating the performance of qualifications of Clinicians, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services. All of these uses and disclosures are more fully outlined in Washington Medical Center's Notice of Privacy Practices.

Request for Information from Others.

I consent to Washington medical Center's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above, and Washington Medical Center's participation in any health information exchange described in the Infusion Center's Notice of Privacy Practices.

4. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received or been offered a copy of Washington Medical Center's Notice of Privacy Practices, which provides information on how Washington Medical Center may use or disclose my health information.

5. **ASSIGNMENT OF BENEFITS**

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to Washington Medical Center for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

6. **FINANCIAL RESPONSIBILITY**

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insuranceor health care benefits, including any and all products (e.g., medications) provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid, or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered products and non-covered services also may include those products and services Washington Medical Center and the Clinicians initially determine to be medically necessary but are later determined unnecessary or denied by my insurance or payer.

7. **PERSONAL VALUABLES**

I understand that Washington Medical Center does not accept responsibility for any lost, stolen, or damaged personal items while I am at the Infusion Center.

Patient Name:______________________________________ Patient Date of Birth: ____________
(Print)

Patient Address:

Street Address:______________________________________

City:____

Zip:_ _ _ _ _ _ ________ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

X ____
Patient Signature or Legal Representative Signature Today's Date

If Signed by Legal Representative, Relationship to Patient (e.g. parent, spouse, etc):

____
(Print Name and Provide Relationship)

OFFICE AND FINANCIAL POLICES

We are dedicated to providing the best possible care and services to you. An essential element of your care and treatment is understanding your financial responsibilities. If you have any questions about the policies, please discuss them with our office staff.

Health Insurance

We are contracted with most insurance plans to accept assignment of benefits. Out office will file your visit with the insurance company and will only collect your co-pay, deductible, and/or coinsurance when it applies. Please note: Our contract with your insurance carrier requires us to collect your co-pay at each visit. If you have insurance coverage with a plan that we do not have a prior agreement with, the charge for your care and treatment are due at the time of service.

Patient Payments

In the event your health plan determines a service "non-covered", you will be responsible for the complete charge. Payment is due upon each receipt of statement from this office unless prior arrangements have been made. I understand that there will be a **$35.00 NSF** fee for any returned checks.

Referrals

It is your responsibility to obtain a valid referral from your primary physician when required by your insurance Company.

Medication History Authority

I grant Washington Medical Center the authority to download my medication history automatically from benefits manager **(PBMs).** This medication history may include prescriptions from all of my treating physicians within the last 12 month period.

I have read and understand the office policies, and I agree that such terms may be amended from time to time by the practice. I hereby assign my insurance benefits to be paid directly to Washington Medical Center.

Signature of Responsible Party

Date

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, representatives of Washington Medical Center may call or mail my home or other alternative location, or leave a message on voicemail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointments, discussion of lab or procedure results, or to ask to call regarding an issue or concern.

I authorize Washington Medical Center and staff to release laboratory results and reports to the following individuals listed below. At no time will a representative of Washington Medical Center discuss your medical circumstances or condition without your consent.

1. _____ Relationship to Patient:_____

2. _____ Relationship to Patient:_____

This authorization shall be in force and effect for one year from the date of signature. I understand thatI have the right to revoke this authorization, in writing, at anytime by sending such written notification to 1351 Jefferson St., Suite 208. Washington. MO. 63090

____ **NO, I do not wish my information to be released to anyone but myself.**

By signing this form I acknowledge that the notice of Privacy Practices was available and that I read (or had the opportunity to read if I choose) and understand the notice.

By signing this form, I am consenting to allow Washington Medical Center and office staff to use and disclose my personal health information to carry out treatment, payment, and health care operations. I also accept full financial responsibilities for any services not covered by my insurance policy/ policies.

_____

Patient Name

_____ _____

Signature of Responsible Party Date