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**CONSENT TO OUTPATIENT SERVICES**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**AUTHORIZATION FOR MEDICAL TREATMENT:** I authorize the physician(s) or therapists in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and x-rays. I acknowledge that no guarantees have been made to me as to results of my treatments, tests, or procedures. I also authorize copies of the medical records to be released to other physicians and health care facilities as deemed necessary by any physician or therapist whose care the patient is under.

**PATIENT RIGHTS:** I, the undersigned, have received a copy of the "A Patient's Guide to Practice Name and Notice of Privacy Practices", informing me of my rights and responsibilities as a patient.

**ASSIGNMENT OF FACILITY BENEFITS:** I/we assign all benefits to Practice Name(s) and authorize direct payment to facility(s), address, all insurance benefits or Medicare/Medicaid benefits to which I/we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I/we agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

**STATEMENT OF RESPONSIBILITY:** I understand that I am financially responsible to Facility(s) as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignment, which charges may include any medical insurance deductibles and co-insurance. I understand that to sign as a Guarantor means that if the patient does not pay Facility(s) for all charges due, I, as Guarantor, will be responsible for such payment.

**NONCOVERED MEDICARE/MEDICAID SERVICES:** Medicare/Medicaid have certain outpatient procedure that are excluded from coverage, including but not limited to those of routine diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare/Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible; the patient will be provided additional information with regard to these charges and limitations on a separate written form.

**AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY/THIRD PARTY PAYOR:** I authorize Facility(s) and any physician, therapist, practitioner, pharmacist, or other person, any hospital including Veteran's Administration or governmental hospital, any medical service organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.

**AUTHORIZATION FOR QUALITY REVIEW:** I acknowledge that it may be appropriate for Facility(s) to review the overall care provided to patients prior to and following the patient's treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of health care provided to Facility(s) patients. Therefore, I authorize the physicians and therapists and any other health care professionals who cared for the patient at Facility(s) to provide Facility(s) with copies of records regarding my care that pertain to the treating diagnosis as needed for quality review purposes. This consent is valid for the care provided to me for up to 12 months before and no longer than three months after my treatment at Facility(s).

**PERSONAL VALUABLES:** Facility(s) shall not be liable for the loss of or damage to any personal property.

**ASSIGNMENT OF BENEFITS:** I/we assign to Medical Staff Physicians and therapists, and authorized direct payment to Facility(s) all insurance benefits or Medical benefits to which we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I/we agree to pay Facility(s) for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

The undersigned certified that he or she has read the foregoing or is the patient or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient's Signature/Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

