



### **General Consent to Treatment**

I request and authorize the physician office, clinic, or outpatient care to provide care to me 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, biological 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 care is directed by my physicians, and that other personnel render care and services to me 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 such diagnostic procedure or treatment.**

I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostics procedures. I authorize the facility to perform other tests on these body fluids and /or tissues in order to further medical research and knowledge and/or dispose of these fluids and tissues.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) 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.

**Co-Pay and/or Deductible Notification**

While we make every attempt to verify the co-pays and deductibles your insurance requires, **YOU ARE RESPONSIBLE** to know your level of financial responsibility for co-pay and deductibles. These amounts are our best estimate of your costs based upon the information available to us.

I have been informed that my insurance requires me to pay a co-pay of \_\_\_\_\_

I have been informed that my insurance requires me to pay a deductible of \_\_\_\_\_

**Non-Network/ Non-Participating Provider**

I understand that I am choosing to be seen today by a non-network and/or non-participating provider. I understand this provider does not participate with my insurance plan or belong to a network other than the one to which I am assigned. I realize that my insurance carrier may only pay part of today's service or may choose to deny the service in full. In either case, I acknowledge that I am fully responsible for the total charges for today's services.

**No Referral on File**

I understand that I am choosing to be seen today without a referral/authorization from my insurance carrier. Without proper referral/authorization, I realize that my insurance company will not reimburse the physician for today's services. I understand that I am fully responsible for today's charges for services rendered.

**Worker's Compensation Waiver Consent**

I understand that I am choosing to be seen today without a letter of authorization. I recognize that the injury(s) I'm being seen for were sustained at work. I have not filed a worker's compensation claim with my employer and wish to bill my private insurance company. I understand that any and all charges not paid for by my private insurance company will be my financial responsibility and I agree to pay in a timely manner.

**Notice and Use and Disclosure of Protected Health Information**

The undersigned acknowledges that he/she has received a copy of the Porretta Center for Orthopaedic Surgery's NOTICE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

**The signature below indicates agreement of the selected items (indicated with a ✓ in the box).**

\_\_\_\_\_

Patient/Guardian Signature

\_\_\_\_\_

Patient/Guardian Printed Name

\_\_\_\_\_

Date