MedStar Health

Submit

Patient:

Location:

DOB:

EMPI:

CONSENT FOR MEDICAL TREATMENT

I hereby authorize the personnel and providers of this medical facility to render such care as they deem necessary and appropriate in their professional judgment.

I understand that I have the right to make informed decisions regarding all care and treatment, and that I should ask the personnel of this medical facility to clarify any details of my care that I do not understand. This includes the right to refuse treatments I do not want.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this medical facility to release any medical information deemed necessary to the identified third party payers and/or legitimate agents of the listed parties to determine benefits payable.

In addition to insurance providers and/or their legitimate agents, I hereby authorize this medical facility to release any information regarding my treatment, which may include medical issues and care, results of tests, and payment, to the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of any insurance, personal injury protection, or other benefits payable to me.

GUARANTEE OF PAYMENT

I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay the medical facility or practice's charges in full when rendered. I also acknowledge that interest may be charged to unpaid balances over thirty days from the date payment is due. In the event that the account is referred to collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (MEDICARE and MEDICAID PATIENTS ONLY)

I hereby certify that the information given by me applying for payment under TITLE XVIII (Medicare) and XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim.

PATIENT RIGHTS AND RESPONSIBILITIES

By signing below, I acknowledge that I have received information about Patients' Rights and Responsibilities.

NOTICE OF PRIVACY PRACTICES: My initials acknowledge that I received the MedStar Health Privacy Practices Brochure.

Initials _____

☐ Patient/Patient Representative declined to acknowledge

☐ Patient/Patient Representative unable/unwilling to acknowledge receipt

I certify that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the patient's representative to sign this document and be bound by its terms.

Patient's Signature _____ Date _____ Time _____

If Patient is under 18 years old or unable to sign:

Authorized Person's Signature _____ Date _____ Time _____