

GENERAL CONSENT FOR HEALTHCARE SERVICES

Family Medicine Center

I, _____, hereby authorize my attending physician and/or such physicians,
(PLEASE PRINT PATIENT NAME HERE)
assistants, and technicians as may be selected by him/her, to diagnose and treat the conditions from which I am suffering by such means including diagnostic, operations and/or surgical procedures, as he/she believes indicated by his/her study of my case.

CONSENT TO CARE: I am presenting myself for diagnosis and treatment, and I voluntarily consent to the providing of such care including diagnostic procedures and medical treatment by employees and agents of the Family Medicine Center and by its Medical Staff as may, in their judgment, be necessary or advisable to treat my condition. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the results of treatments or examinations at the Family Medicine Center

PRIVACY NOTICE AND USE OF PROTECTED HEALTH INFORMATION (PHI):

I acknowledge that I have received the Notice of Privacy Practices of the Cleveland Clinic Health System (CCHS). I understand that the Notice of Privacy Practices explains how CCHS may use and disclose confidential health information that identifies me. I consent to let CCHS use and disclose health information about me as described in the Notice of Privacy Practices. This includes information about substance abuse, mental health services and HIV if applicable. I consent to the release of health information to my insurer, other third party payers, and any agents or consultants that assist in my treatment, help CCHS get paid or carry out its health care operations.

GUARANTEE OF ACCOUNT:

In consideration of facility services to be rendered, I guarantee payment to this facility for all charges incurred on behalf of the above named patient, including any portion not paid by any insurance organization, Medicare or Medicaid. **Many insurance carriers require patients to call and receive prior authorization/notification for an admission or a procedure to be covered.** Failure to comply may result in the patient or guarantor being responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS:

In consideration of facility services to be rendered, I assign, transfer and convey all of the rights, titles and interest due me from any insurance organization, Medicare or Medicaid in payment on my behalf to this facility. I authorize the Social Security Administration to release to this facility information regarding my Medicare entitlement. This authorization will remain in effect for all inpatient and outpatient care provided by this facility until expressly revoked in writing by me. In the case of clinic patients, this authorization will remain in effect for one year from the date of this signature.

I acknowledge that the treatment for which I give this consent has been fully explained to me and I have read and fully understand this authorization as it applies to me.

Signed _____ Date _____ Date of Birth _____
(IF MINOR, MUST BE PARENT/GUARDIAN)

May we call your home phone and leave a message on a machine, or other person at your home? Yes NO

Who may we speak to regarding your medical care? **Please provide names and phone numbers.**

EMERGENCY CONTACT (Name) _____ Phone _____

_____ My Spouse _____

_____ My Son / Daughter / Parents: _____

_____ Others (Please be specific) _____

_____ None of the above. **Do NOT discuss my medical care with anyone other than me.**