

Health Care Consent Form

Patient Name: _____

Patient MR#: _____

This form covers Health Care services provided by:

BodyWorks, Inc.

CONSENT FOR CARE AND/OR TREATMENT

I agree to:

- ⌘ Have outpatient treatment(s)
- ⌘ Have treatments/tests my doctor suggests
- ⌘ Have a wellness program developed

I am aware:

- ⌘ There are no guarantees for the results of treatments and exams.
- ⌘ I have the right to have a treatment or test my doctors believes is needed.
- ⌘ Doctors-in-training (residents), students in health-related programs (such as physical therapy students) and others may observe or take part in my care.
- ⌘ Agencies may be contracted to help to provide medical care and treatment at this facility.

CONSENT FOR USE/RELEASE OF MEDICAL INFORMATION

I understand I may change or cancel the following releases at any time unless the event has already occurred. This consent covers the release of medical information or records, including information, if any, regarding HIV status, AIDS, or Human Immunodeficiency Virus. An additional consent/authorization to release information about treatment for alcohol and/or substance abuse may be required.

Release of information for payment purposes. I agree that the Facility and my doctors/dentist can give information about my outpatient treatment to any party, government or charity that may be responsible for paying for my care. Only the information needed eligibility determination, payment or discharge planning will be given.

Release of information for treatment, health care operations and/or quality assurance purposes:

I agree that:

- ⌘ My doctors/dentist, Facility staff, and persons from regulatory or accrediting agencies can see my medical records for information needed to provide care or to do quality assurance reviews.
- ⌘ My medical records may be sent to the doctor who referred me to this Facility and to any health care facility, extended care facility or doctor who I may be referred.

FINANCIAL RESPONSIBILITY

I (the patient) agree to pay the facility for all charges for services and incidentals provided to me. Full payment is due within 30 days of billing. I am aware that some services may not be currently covered by my insurance and that fees will be paid by me privately to the facility.

Insurance Benefits: I agree that:

- ⌘ Any surgical, medical, or other (including major medical) benefits due to me under my health care plan shall be assigned (paid) directly to the Facility. **(SENDING THE INSURANCE CLAIM IS A SERVICE AND NOT A GUARANTEE OF PAYMENT.)**
- ⌘ I also irrevocable assign to the hospital all rights, titles, and interest in any compensation received or to be received from any source as a result of injuries sustained by me (patient), and
- ⌘ If my insurance company requires prior approval for services, it is my responsibility to get it.
- ⌘ I am personally responsible for paying the Facility and doctors/dentist for charges not covered by my insurance. I may choose to continue to receive these non-covered services even though I will be responsible for the charges.
- ⌘ If I not agree to allow the facility to bill the insurance company or if my insurance company does not allow the Facility to be paid directly, or if I do not authorize the release of my medical records that may be needed to pay a claim, I understand that I am responsible for paying the bill.
- ⌘ I also consent to the release of my medical records and other related information to my insurance company and authorize the facility to appeal, on my behalf, any denied claim(s).

Medicare/Medicaid/Federal and State Programs

- ⌘ In the event that I may qualify for Medicaid, or any other federal/state program, I consent to being referred to the Department of Social Services, or other applicable agencies and authorize the Facility to receive information regarding that referral and/or application.
- ⌘ The information I gave when applying for Medicare, Medicaid, or federal/state programs is correct. I give permission to the Facility and doctors to receive payment from any of these programs for services rendered to me.
- ⌘ I give permission to the Facility to release my medical information to Medicare/Medicaid/Federal and State Programs in order to receive payment for this and any other related claim(s).

Transferring Credits

- ⌘ I am aware that excess money paid to the Facility and due as a refund to me may be transferred to other bills at the Facility for which I am responsible.

PERSONAL VALUABLES

The Facility is not responsible or liable for my personal property or valuables.

My signature indicates approval of the terms on this form except for section(s) marked.

Patient Signature

Date

Witness

Date

If a patient is not able to consent or is a minor, complete the following

Responsible Co-Signer/Authorized/Legal Representative

Date

Witness

Date

Patient is unable to consent because: _____ a minor _____.

Responsible Party/Legal Rep.

Relationship

Date

Witness

PRIVACY NOTICE

NOTICE OF PRIVACY: BodyWorks Inc., has a Notice of Privacy that states how we may use and release your health information. A copy of the Notice of Privacy will be made available to you. Please let us know if you have questions about the Notice. By signing below, you (or your legal representative) agree that you been offered the opportunity to review our Notice of Privacy and understand its terms.

Patient /Legal/Responsible Party Signature

Date