MONMOUTH FAMILY HEALTH CENTER INC.

General Consent: Outpatient Facility

FOR OFFICE USE ONLY

CONSENT TO CARE: I wish to be treated by Monmouth Family Health Center. While I am a patient, I permit my doctor(s), Center employees, and all the persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations, and medical treatment. I understand that Monmouth Family Health Center is a teaching facility and that medical students and residents may participate in my care and treatment. I understand that no guarantees have been made to me about the outcome of this care.

RECURRING VISITS: If the services rendered qualify me for recurring status, my signature hereon shall be valid for care rendered throughout this period. If, during this period, any of my registration information changes i.e. address, phone, employment, insurance guarantor etc., I will notify the Center of the change.

PERSONAL VALUABLES: I understand that I am responsible for any valuables brought into the Center. The Center will be released from all responsibilities in the event of the loss of my personal property.

RELEASE OF INFORMATION: I understand that my medical records are kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. This may include remote access to electronic records from physicians' offices. The Center may seek, release and verify all or part of the patient's medical and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to the Center, the patient, family member, or employer of the patient for all or part of the Center's charges. I **consent to the release of medical information for purposes of discharge planning; I consent to the release of my identification and general condition. I understand that limited information may be utilized for Monmouth Family Health Center patient satisfaction surveys.**

FINANCIAL AGREEMENT: For and in consideration of services rendered I agree to make prompt payment to Monmouth Family Health Center when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, co-payments, and/or coinsurance. If I am classified as a self-pay patient a deposit will be requested. I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to seeking services. If my insurance carrier, or its intermediaries, or the Professional Review Organization deems that medical and or professional services to be given or already given are not medically necessary and/or are non-covered services I must pay for those services. BY MY SIGNATURE BELOW, I HEREBY CONSENT TO MONMOUTH FAMILY HEALTH CENTER ACTING ON MY BEHALF, DISCUSSING WITH OR APPEALING TO MY HMO, ITS MEDICAL DIRECTOR AND/OR ITS PHYSICIAN DESIGNEE OR OTHERWISE TAKING ACTIONS WITH RESPECT TO ANY UTILIZATION MANAGEMENT, PAYMENT, OBLIGATORY OR OTHER DETERMINATION MADE CONCERNING THE PROFESSIONAL MEDICAL SERVICES PROVIDED OR TO BE PROVIDED TO ME BY MONMOUTH FAMILY HEALTH CENTER AND ITS PROFESSIONAL STAFF, IN ACCORDANCE WITH MY HMO'S INFORMAL (STAGE I) AND FORMAL (STAGE II) APPEALS PROCESS AND APPLICABLE LAW. I CONSENT TO MONMOUTH FAMILY HEALTH CENTER PURSUING SUCH APPEALS ON MY BEHALF; HOWEVER, I RECOGNIZE THAT MONMOUTH FAMILY HEALTH CENTER HAS NO OBLIGATION TO PURSUE SUCH APPEALS.

PRE-CERTIFICATION: **I acknowledge that pre-certification requirements have all been met.** ☐ YES ☐ NO ☐ N/A

ASSIGNMENT OF BENEFITS: I authorize payment directly to Monmouth Family Health Center or health insurance benefits payable under terms of my policy but not to exceed the balance due for services performed during this period of treatment.

FINANCIAL ASSISTANCE: I have received a copy of the notice of Financial Assistance and reduced Charge Financial Assistance. I understand I may be eligible for financial assistance but must apply to receive it.

MEDICARE AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST: I certify that the information given by me in applying for payment under the Title XVIII 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 a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize such a physician or organization to submit a claim to Medicare for payment. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THIS EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

MEDICARE:	☐ N/A		
I am entitled to benefits under Medicare Insurance, Part A	☐ YES	☐ NO	☐ N/A
I am entitled to benefits under Medicare Insurance, Part B	☐ YES	☐ NO	☐ N/A

ADVANCE DIRECTIVE:	☐ Under 18		
I have an Advance Directive/Living Will/Health Care Agent	☐ YES	☐ NO	☐ N/A
I am providing a copy to Monmouth Family Health Center	☐ YES	☐ NO	☐ N/A
I received Advance Directive Information	☐ YES	☐ NO	☐ N/A

- I acknowledge receipt of the Ambulatory Patient's Bill of Rights and have been advised of my right to an Advance Directive
- I understand that if I do not comply with the pre-certification requirements, I will be responsible for charges
- I have read this form, my questions have been answered, and I understand and agree to its content
- I acknowledge receipt of Monmouth Family Health Center's notice of HIPAA Privacy Practices

Patient Signature/Authorized Representative _____ Relationship _____ Date _____

The Patient is unable to sign because: _____ Witness to signature only _____