metropolitan familyhealth network

GENERAL CONSENT/ AUTHORIZATION FORM

1. CONSENT TO TREATMENT

I assign and hereby consent to treatment at this MFHN facility and authorize each of its physicians, practitioners, health care professionals, employees and members of its medical, dental and behavioral health staff to render care. I understand that the medical care that I receive at this facility may include, but may not be limited to, laboratory tests, diagnostic procedures, therapy, examinations and administration of medication, etc. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury, or death. I understand and acknowledge that no guarantees have been made to me about the outcomes of my care.

2. RELEASE OF INFORMATION

I hereby authorize MFHN to release part or all of my medical record for treatment or healthcare operating purposes (as necessary to either determine eligibility for health benefits or verify, collect or pursue my account) to any person, corporation, agency or entity that is either responsible for payment of the cost of care provided to me, or involved in the collection, processing, verification, or payment of my account, regardless of whether I am eligible for reimbursement by a third-party payer. My consent to the release of this information is subject to revocation at any time, except to the extent that the party which is to make the disclosure has already relied upon my consent.

I authorize MFHN to release my medical record to outside healthcare institutions, agencies, or physicians as necessary to maintain continuity of care. I acknowledge I have been provided with Metropolitan Family Health Network, Inc.'s HIPAA "Notice of Privacy Practices" and "Patient Rights" to read. Any questions have been answered to my satisfaction.

_____ _____ _____

PATIENT OR PERSON SIGNING ON PATIENT'S BEHALF **RELATIONSHIP** **DATE**

3. ASSIGNMENT OF BENEFITS

I authorize payment directly to MFHN for hospital/medical insurance benefits (from Medicare, Medicaid, commercial insurance, worker's compensation, auto insurance, other insurance carriers, etc.) that MFHN might be entitled to for the charges of the care/treatment provided to me.

4. FINANCIAL AGREEMENT

In consideration of the care and treatment provided, I hereby guarantee payment of all charges not covered or paid by my insurance benefits including Medicare, Medicaid, worker's compensation and no-fault insurance. I hereby agree to all precertification requirements as stated in my health insurance policy.

5. PERSONAL VALUABLES

I understand that MFHN is not responsible for the loss of, or damage to, any valuable such as money or personal articles.

6. AUTHORIZATION TO PAY PHYSICIAN

Note: In addition to your medical bills from MFHN, you may also receive separate bills from the laboratory for their services.

I hereby authorize payment directly to any and all of my treating physicians and/or laboratory benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by my health insurance benefits.

ACKNOWLEGEMENT

I hereby acknowledge that I have read (or have had this consent form read to me) and understand this form. I further acknowledge that any questions I had were answered to my satisfaction. I hereby agree and accept the terms of this form.

_____ _____

PATIENT OR PERSON SIGNING ON PATIENT'S BEHALF **RELATIONSHIP TO PATIENT**

_____ _____

REASON FOR PATIENT NOT SIGNING CONSENT **DATE**

_____ _____

WITNESS TO BOTH AKNOWLEDGEMENT SIGNATURES ABOVE, **DATE**

Revised 12/1/17-SC