COMMUNITY Medical Centers

General Medical Consent

PLACE LABEL HERE

Before you give your consent, be sure you understand the information given below. We will be happy to answer any questions you have. You may ask for a copy of this form.

Consent for Treatment: I request Community Medical Centers, Inc. (CMC) to provide me with health care services. I will be given information about the test(s), treatment(s), procedure(s), and medication(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I hereby request that a person authorized by Community Medical Centers, Inc. provide appropriate education, evaluation, testing, and treatment.

Community Medical Centers, Inc. (CMC) uses clinicians that are credentialed through CMC's board of Directors, and licensed through their respective boards in the state of California, including, but not limited to Physicians, Nurse Practitioners, Physician Assistants, Podiatrists, Optometrists, Physical Therapists, and Licensed Clinical Social Workers. I understand CMC may utilize certain telehealth technologies if appropriate. **If necessary, I will be given outside referrals for further diagnosis or treatment. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care.**

Release of Information: I understand that confidentiality will be maintained as described in *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described in *Notice of Health Information Privacy Practices*.

CMC participates in an electronic medical record exchange program and shares limited information about me with other health care facilities and providers that participate in the program for purposes of the delivery of care and services to me. I understand this exchange includes information, such as but not limited to, my name, date of birth, and contact information.

I understand that all services are confidential. In cases of life threatening emergencies and physical or sexual abuse, CMC may need to make a referral to another agency.

Interpretation Services: I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services will be provided if needed.

Use of Technology: I understand CMC uses a variety of electronic communication methods including phone, text messages, e-mail, to communicate with me for the limited purposes including of appointments, available services and other healthcare related communications. I understand that text and/or data charges may apply under my cell phone plan. I consent to allow CMC to use telehealth technologies for the purposes of the delivery of services to me. If I decide I do not want CMC to use telehealth technology as part of my care plan I will let my provider know.

Photography and Video: I understand that photographs, videotapes, digital and other images may be recorded to document my care, and I consent to this. I understand that these images will be stored in a secure manner that will protect my privacy.

Assignment of Insurance Benefit: I hereby authorize payment directly to CMC of benefits otherwise payable to me but not to exceed CMC's regular charges for this service. **I understand that I am financially responsible to CMC for any charges not covered by my insurance.**

Financial Agreement: I agree to pay all charges that are not payable by insurance or third party. I agree to abide by the terms and conditions of CMC's Collections Policy, and agree to pay for attorney fees or other expenses incurred in the collection of payment due.

In accordance with CMC's Collections Policy, CMC may choose to terminate its relationship with any patient who does not comply with this financial agreement.

Statement to Permit Payment of Medicare Insurance Benefits to CMC: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf.

Acceptance of Responsibility for Co-Payments: I understand that I am responsible for any health insurance deductibles or co- payments, including a twenty percent (20%) co-payment for authorized services covered by Medicare.

In the state of California minor patients (under the age of 18 years of age) may be allowed to consent to services without the parent/guardian being present, including emergency services, family planning services, and services related to sexually transmitted infections/diseases.

I hereby acknowledge receipt of Community Medical Centers, Inc. *Notice of Health Information Privacy Practices*. The undersigned certifies that he/she has read and understood the information above and authorizes services by Community Medical Centers, Inc. as the patient or as the patient's general agent and accepts its terms.

_____
Print Name

_____ _____
Signature of Patient or Legal Guardian **Date Signed**

Relationship to Patient (if applicable): ❑ Spouse ❑ Parent/Guardian ❑ Other: (specify)
_____

_____ _____
Minor Patient **Date Signed**

_____ _____
Witness **Date Signed**