**Authorization for Medical/Surgical Treatment**
**Consent to Treatment, Statement of Patient Rights and Release of Information**

1. **Informed Consent:** I have been informed by my healthcare provider of the nature and purpose of my clinical visit. I voluntarily consent to the medical and surgical treatment and procedures, x-rays and laboratory tests that provider(s) request.
2. **No Guarantee:** I understand medicine and surgery are not exact sciences, and diagnosis and treatment may involve risks of injury or death. I understand and acknowledge that no guarantee or assurances as to results have been made.
3. **Advance Directives:** I understand I have the right to make decisions, by law, concerning my medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives regarding this.
4. **No Smoking:** I understand the Three Rivers Hospital Campus is a Tobacco-Free area. I understand that I may not use or consume any tobacco products in any Three Rivers Hospital owned or leased facility. Nor can I use or consume tobacco products in hospital parking lots, or the sidewalks and streets adjacent to hospital owned or leased facilities.
5. **Financial Agreement and Payment Guarantee:** Both undersigned patient and the guarantor(s) agree that in consideration of the services to be rendered to the patient, they hereby individually obligate themselves to pay the charges of the hospital in accordance with the regular rates and terms of the Hospital. I understand that my insurance carrier may not cover all costs associated with my care and that I may be obligated to pay balances not covered by my insurance coverage. Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.
6. **Assignment of Insurance Benefits:** I hereby authorize payment directly to Three Rivers Hospital of hospital benefits otherwise payable to me including major medical insurance, payment of surgical or medical benefits, any party liable to patient and payments to the attending physician employed with TRH. I understand that I am financially responsible to the hospital and physician for charges not covered by this assignment.
7. **Medicare/Medicaid:** I certify that the information given by me in applying for payment under Titles XVIII and XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished me by, or in, Three Rivers Hospital, including physician's services. I authorize any holder or medical or other information about me to be released to the Centers for Medicare and Medicaid Services (CMS) agents including any information necessary to determine these benefits or related services. I have received a copy of the "Important Message from Medicare" Notice (Inpatient Admissions Only).
8. **Release of Information:** I authorize and consent to the release of information related to treatment, **including medical diagnosis, drug and/or alcohol related diagnosis and procedures, AIDS or other sexually transmitted diseases,** to the practitioners or medical organizations responsible for follow up care as well as to any person or organization authorized by law or to a third party payer who may provide insurance payments to the hospital for the charges incurred for the services rendered to the patient.
9. **Consent to Photograph:** I understand that it may be necessary for photographs, videotaping and other imaging of my care be made for treatment, educational or operational purposes. I consent to the recording of these images provided that I am not specifically identifiable by writing or by depiction.
10. **Patient Rights and Notice of Privacy Practices**: I have been provided information about my rights. I acknowledge the hospital will use my information for purposes of treatment, payment and health care operations. I have been given a copy of and have been provided the opportunity to review the hospital's Notice of Privacy Practices. I understand that if I have questions or complaints I may contact the Hospital Privacy Officer.

**By signing below, I acknowledge I have read and understand this document and understand its terms.**

| | |
|---|---|
| _____ | _____ |
| **Patient** | **Witness** |
| _____ | _____ |
| **Patient Representative/Guarantor & Relationship to Patient** | **Date** |

THREE RIVERS FAMILY MEDICINE

*Revised: 03.15.2017*