

**GETWELL INTERNAL MEDICINE
PATIENT CONSENT AND AUTHORIZATION FORM**

Patient Name: _____

Date of Birth: _____

Address: _____

Phone #: _____

Acknowledgement of Notice of Privacy Practices:

By my initials hereto and signature below, I verify that I have been given the HIPAA Notice of Privacy Practices, which provides me with the information of how my Protected Health Information (PHI) is used. _____ **(initial)**

Revocation:

I understand I have the right to authorize and/or restrict the release of my PHI to certain third parties, and I may revoke any authorization agreed to herein, at any time, with a signed written notice addressed to: Getwell Internal Medicine, Attn: _____, address _____. I understand my revocation is not effective until it is received by Getwell Internal Medicine. I understand that the authorizations agreed to herein do not expire until the date of revocation. _____ **(initial)**

Consent to Treat:

By my initials hereto and signature below, I voluntarily seek and consent to medical treatment at Getwell Internal Medicine. This consent includes examination and treatment by the physicians, nurses and other health care professionals at Getwell Internal Medicine. I also consent to any medical procedures, CT scans, Ultrasound, laboratory tests and/or other health care services ordered by Getwell Internal Medicine. I understand that I may refuse specific treatments or procedures by informing a health care professional of such refusal. _____ **(initial)**

Medical Records:

Medical records cannot be sent to any other provider or third party without written permission from you (please see the Authorization for Release of Protected Health Information form), which permission may be revoked by you at any time, in writing. _____ **(initial)**

Test Results:

Test results cannot be left on your voicemail or answering machine or discussed with another family member, even your spouse, without your written permission. By my initials hereto and signature below, I authorize that Getwell Internal Medicine may leave information regarding test results with the following individual(s): _____ **(initial)**

Name of Person: _____ Relationship to Patient: _____

Name of Person: _____ Relationship to Patient: _____

Confirmation of Appointments:

As a courtesy to you, we do call prior to the day of your appointment to confirm the time and date of your appointment. This information cannot be left on your voicemail or answering machine or related to someone else without written permission. By my initials hereto and signature below, I authorize Getwell Internal Medicine to leave appointment reminder information by voicemail, answering machine or with the person who may answer my phone number. _____ **(initial)**

Discussion of Your Account/Payment Responsibility:

We cannot discuss your bill with anyone without written permission, including your spouse or any other family

member, unless they have a power of attorney on file. By my initials hereto and signature below, I give Getwell Internal Medicine permission to discuss billing information with the following individual(s): _____ **(initial)**

Name of Person: _____ Relationship to Patient: _____

Name of Person: _____ Relationship to Patient: _____

Assignment and Release:

By my initials hereto and signature below, I assign directly to Getwell Internal Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I agree that in the event of non-payment for services provided, I accept full and complete responsibility for the balance due, collection costs, court costs, as well as any attorney fees should legal action become necessary. I authorize the use of my signature on all insurance submissions. _____ **(initial)**

Getwell Internal Medicine may use my health care information and may disclose such information to the named insurance company or companies (as listed on the patient registration form) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ **(initial)**

Patient (or Guardian) Signature: _____ Date: _____

Printed Name of Patient (or Guardian): _____