Primary Care Partners
Affiliated with
Atlantic Health System

Consent for Treatment, Payment and Healthcare Operations

This form cannot be modified. Any handwritten changes to this form shall not be legally binding or enforceable

General Consent, Authorization, Patient Rights and Responsibilities

I authorize Primary Care Partners ("PCP'), PCP care center)_____PCP staff and physician(s) participating in my care to render medical care for my condition, which may include routine diagnostic procedures and such other medical treatment as may be deemed advisable by the physician(s) participating in my care. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand the doctors in training, medical and nursing students, and paramedical personnel may observe and participate in my care under the supervision of PCP staff and my Physician(s). I authorize PCP (care center) - _____ to arrange for the disposition of all specimens and tissues. I understand that it may be necessary for my healthcare provider(s) to take photograph, films, recordings and/or other like images and that the presence of a vendor representative may be required for medical, educational and /or continuity of care purposes.

I hereby acknowledge receipt of a Statement of Patient Rights and Responsibilities. I understand that professional personnel are available to explain the statement.

Financial Arrangements

I understand that I am financially responsible for the payment of my physician fees and these fees may not be covered by my insurance plan. I authorize payment of medical insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to any physician(s) participating in my care. I understand that some insurances and managed care entities require pre-approval of certain hospitalizations, procedure, and surgeries, and it may be my responsibility to obtain appropriate approvals. In addition, a deposit may be requested if I have been classified as a self-pay patient. I authorize PCP , and all the clinical providers who have providers who have provided care to me , along with any billing services , collection agencies , attorneys or other agents who may work on their behalf , to contact me on my cell phone, and/or home phone using automatic telephone dialing system or other computer assisted technology.

☐ **I do not authorize such contact at this time.**

Protected Health Information

I have received a copy of the Notice of Privacy Practices for Protected Health Information. This notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI"). I have had an opportunity to review this information before signing this form. I consent to Primary Care Partners and providers participating in my care releasing my PHI (either in writing or verbally) in order to carry out treatment, payment, or healthcare operations. This includes any medical information (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV related information including HIV testing results (if applicable) , which may be needed to process claims for medical insurance (or managed care) benefits relative to physician visits, or which may be needed to conduct continued care planning.

Authorization to Draw Blood

In the event that any individual participating in my care is accidentally exposed to my blood or bodily fluids. I authorize PCP to draw my blood and test it for the presence of blood borne pathogens such as Human Immunodeficiency Virus ("HIV"). I understand that if such testing is necessary that PCP or my physician will make all reasonable efforts to notify me. I consent to the confidential disclosure of the test results to the authorized medical provider treating the person exposed to my blood or bodily fluids, so that the appropriate treatment determinations may be made.

☐ **I decline to be tested for HIV and refuse the disclosure of my blood results.**

Print Patient Name: _____Medical Record #_____

_____ (am) (pm)

Signature of Patient Date Time

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not acceptance of financial responsibility which I would not otherwise have for services rendered.

_____ (am) (pm)

Signature of Person Signing on behalf of Patient Date Time

_____

Printed Name of Person Signing on behalf of Patient Relationship

Patient unable to sign because_____

_____

Signature of Witness (PCP Employee) Date Time