ST. ELIZABETH PHYSICIANS

General Consent for Treatment

Name of Patient _____ **Date of Birth** _____

I consent to and authorize the physician(s), physician assistant(s), nurse practitioner(s), resident physician(s), health care student(s) and/or clinical staff of **Our Lady of the Ascension d/b/a St. Elizabeth Physicians ("STEP")** to provide diagnostic procedures and medical treatment including, but not limited to minor procedures and routine services deemed necessary at the time of the office visit, to me or the patient named on this form. I understand that the practice of medicine is not considered exact science, and acknowledges that no guarantees have been made to the patient named on this form.

The following 2 sections may or may not apply to this clinic. If you have any questions, feel free to discuss with your provider.

Photography and Other Recordings
I consent to photographs, audio and video recordings, digital or other images that may be recorded for treatment purposes. I understand that these images may be used only for treatment and that these images will be stored in a secure manner.

Medical Education
I agree that STEP care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty and/or STEP staff, in accordance with the policies of St. Elizabeth Physicians.

Acknowledgement of St. Elizabeth Physicians Notice of Privacy Practices
I have received / been offered a copy of the **STEP** Notice of Privacy Practices. _____(Initials)

NOTICE TO MINORS
Your healthcare provider has the right to disclose protected healthcare information to your parents/guardians should he/she deem necessary.

Payment Guarantee & Insurance Authorization/ Assignment of Insurance Benefits
I agree to pay for all charges for diagnostic procedures and medical treatment and understand that payment is due at the time of service. I understand if I do not have medical insurance, financial arrangements must be made prior to services rendered. I further authorize third parties to pay directly to **STEP** any insurance benefits due for services rendered on behalf of me or the named patient. I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to **STEP**. I agree to notify **STEP** of any changes in insurance, address or other information included in patient registration. I understand I am responsible for all charges not paid by my insurance company. If it becomes necessary to collect any sum due through an attorney, then, I agree to pay all reasonable costs of collection including attorney's fees, whether suit is filed or not. Additionally I agree to pay court costs associated with such collection efforts.

Acknowledgement
By signing this agreement, I acknowledge that I have read and understand information contained in this consent form, and that I accept its terms.

Patient Signature:_____Initials: _____ Date: _____

If patient is a minor or unable to consent, consent will be obtained from:

Name: _____

Signature (on behalf of patient): _____ Date: _____

Relationship to patient: _____