**NESS CITY MEDICAL CLINIC**

316 Custer Ness City, Kansas 67560

Phone: (785) 798-2233 Fax: (785) 798-3302

 PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PATIENT DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PHYSICIAN CLINIC TREATMENT AUTHORIZATION******AND PRIVACY ACKNOWLEDGMENT***

This treatment authorization will be renewed on an annual basis.

1. CONSENT FOR TREATMENT: I consent to radiographic and ultrasound examinations, laboratory procedures, anesthesia, medical treatment, surgical treatment, Clinic services, immunizations, pharmaceutical services (including such services provided based upon my prescription medication history obtained from other healthcare providers or third party benefit payors) and/or other services rendered under the general and special instructions of my attending or consulting physicians. I also consent to the presence of other medical and paramedical personnel, which may include medical and paramedical personnel participating in training programs through the Clinic’s partnership with area training programs (for example, residents, nurses, CRNAs) during the operation, procedure, or delivery of services. I understand that my treatment is under the control of my attending physicians, their assistants or designees, and that they may utilize telemedicine or other electronic technologies to communicate or consult with other providers involved in my care. I understand that if I desire private duty nursing care, I or my family must arranged for such care, and the Clinic shall be released from any and all liability arising from such care. I understand that I will be asked to provide specific consent for certain diagnostic studies, surgeries or other treatment procedures. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services. I understand that any licensed medical personnel involved in the operation, procedure, or delivery of services will act within the scope of their licensure.

2. CONSENT FOR BLOOD/BODY FLUID TESTING: I consent to have the Clinic determine by laboratory testing whether or not my blood contains contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health, the health of my family, or the health of any health care personnel or emergency response person(s) who may have been exposed to my blood or bodily fluids.

3. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS. I agree that the Clinic may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

4. CONSENT FOR PHOTOGRAPHY, AUDIO, VIDEO RECORDING. I agree that medical images, photographs, audio recording, digital recording or video recording may be made while I am receiving treatment in the Clinic. I understand that the images and audio from such photography and recording may be used for my treatment.

5. AGREEMENT TO PAY FOR SERVICES: I agree that in consideration of services to be rendered to me or to the patient for whom I am signing this authorization, I hereby obligate myself to pay the charges of the Clinic in accordance with its regular rates and terms. I also understand that services may be provided by individuals who are not employed by the Clinic who will bill me separately for their services.

6. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign insurance benefits otherwise payable to me directly to the Clinic. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay any interest incurred and the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

7. MEDICARE/MEDICAID BENEFITS: I authorize the Clinic to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the Clinic for services furnished to me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Clinic.

8. PERSONAL VALUABLES/BELONGINGS: I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Clinic CANNOT AND WILL NOT accept responsibility for loss of any of my valuables/belongings, if they are lost or misplaced.

9. REPORTING CERTAIN DISEASES: Certain diseases and conditions, including cancer, are required by law to be reported. I understand that the Clinic will comply with its legal reporting obligations by submitting the necessary information to the proper authorities.

10. CONTRABAND WEAPONS/DRUGS: I agree that should the Clinic find contraband weapons (including a gun without a concealed carry permit, or carried in a facility that is not covered by the law or has obtained an exemption), illegal drugs, and/or prescription drugs for which there is not a valid prescription, nonprescription drugs that are not sold over-the-counter, or any other type of contraband within my possession, on or near my person or in my room, these items will be confiscated and reported to the authorities

11. PROVIDER NON-DISCRIMINATION ACT: I understand that Clinic is an equal opportunity institution and will not discriminate because of race, color, religion, natural origin, age, sex, sexual orientation, handicap, or ability to pay.

12. NOTICE: Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

13. ADVANCE DIRECTIVE INFORMATION: (complete for all patients including outpatients)

 **YES NO**

| Do you have a living will?  |  |  |
| --- | --- | --- |
| Do you have a Medical Durable Power of Attorney (DPOA)? |  |  |
|  If yes, is the living will or DPOA on file? |  |  |
|  If no, were you given Advanced Directive Education Material? |  |  |

14. CONSENT FOR CONTACT BY LANDLINE OR CELLULAR TELEPHONE NUMBER. I hereby consent to Clinic, or its agents or representatives, contacting me by the following means (even if the Clinic, or its agents or representatives, initiate contact using an automated telephone dialing system (ATDS) and/or an artificial or prerecorded voice): (1) paging system: (2) cellular telephone service; (3) landline; (4) text message; (5) email message; or (6) facsimile.

***PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING***

15. CONSENT TO DISCLOSE GENERAL INFORMATION. I understand that my name, location in Clinic, and general condition may be provided to any person asking about me by name, and to members of the clergy, my family, individuals involved in my health care, for disaster relief efforts, or as required by law. **I do \_\_\_\_\_ do not \_\_\_\_\_** give consent for this information to be disclosed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Patient/Personal Representative Signature or Initial)**

16. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I hereby acknowledge that there is a copy of the Clinic’s Notice of Privacy Practices available to me so that I may take it with me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Patient/Personal Representative Signature or Initial**)

17. I understand that immunization data will be submitted to the Kansas Immunization Registry.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Patient/Personal Representative Signature or Initial**)

**I certify that I have read and fully understand this document. I understand that a copy of this document is available to me. I, individually, or as the patient’s personal representative, by signing this document agree that I agree with all of its content.**

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**Patient/Personal Representative**   **Relationship to Patient Date/Time:**

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**Signature, Witness**  **Date/Time**