



PATIENT CONSENT

NAME: _____ DOB: _____

TO OUR PATIENTS: Before you begin treatment at the Heart Center for excellence (HCE), the law requires that we explain your rights and responsibilities while a patient at HCE. If you have a complaint or concern about your care, please discuss it with your Provider. If your concern remains unresolved, you may call the Director of Patient Relations (269-381-3963 or 800-632-7737 ext.408). Please read and sign this form below. Please ask questions if you do not understand the information provided.

Initial Box to Indicate approval

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that this could include lab tests, x-rays, education or other diagnostic procedures. I understand that my Provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW: I understand that it is important that medical providers have access to any of my medical records that will help them to safely treat me and manage my medical care. I agree and understand that a copy of my medical records including AIDS, HIV, Behavioral Health Service, Psychiatric Care, and treatment for Alcohol or Drug use will be included as part of my health information for purposes of my Medical care and for business operations. I also agree that HCE can release my medical records to accrediting or regulatory agencies if those agencies request my records and if the law allows those agencies access to my records. **(Records are automatically sent to your referring physician. A separate form is required with written consent provided by the patient.)**

**The following individuals or companies may have access to my medical information at HCE:
Please list by name (i.e. Wife: Jane Smith):**

I understand that without my explicit permission, HCE is not permitted to speak with family members, friends, and other non-medical persons about my care and treatment with HCE.

PARTICIPATING INSURANCE / MEDICARE / MEDICAID ASSIGNMENT OF BENEFITS- PAYMENT OF HCE MEDICAL BILLS: I would like a “third party payer” (for example, my insurance company/Medicaid/Medicare or its related organizations) to pay the bills for my services at HCE, to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the “third party payer” be made to HCE on my behalf for any services furnished to me by or in HCE. I assign the benefits payable for physician services to the Heart Center *for excellence* or physician furnishing the services. In consideration of clinic visits, I agree to pay HCE for all changes not covered by any third party payer.

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES: In many instances, a “third party payer” will pay a portion or all of my medical bills related to today’s visit. Examples of “third party payers” are medical and auto insurance companies, worker’s compensation insurance carriers, Medicaid, Medicare or its related organizations. In order for a “third party payer” to pay any or all of my bills related to today’s visit at HCE, there needs to be signed authorization to release any information about the medical care and treatment that I receive. I authorize HCE or its related entities to release to the “third party payer” any information needed to determine the payments related to the medical treatment I receive.

RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH: Medical records may be reviewed to answer questions about how your care was delivered, the quality of care received or to identify a patients eligibility for a medical research study. Initialing this box means that your records can be reviewed by select individuals at HCE for help in these kinds of studies. It also means that your provider may contact you about your interest in a study. No personally identifiable information will be shared with outside parties without your written consent. Checking this box does not affect your treatment in any way.

PATIENTS RIGHT TO PRIVACY: I acknowledge that I have been made aware of HCE’s privacy practices and HIPPA regulations, which are posted in the reception area. I have been offered a copy of HCE’s notice of Privacy Practices to keep for myself.

AUTHORIZATION TO COMMUNICATE VIA ANSWERING MACHINE, ETC: I authorize HCE to leave messages about my Private Health Information on my home answering machine, with an individual who answers your home phone or e-mail if I have provided that information. We may call your place of employment to give you information about your visit, discuss your care with the caregiver who brings you to our office, or to relatives who have shown an interest in your care; we may schedule appointments for follow-up visits or diagnostic tests while you are at our check-out window.

I understand I have the right to revoke this consent, in writing, at any time except where The *Heart Center for excellence* has already made a disclosure in reliance on this consent. This consent will remain in effect unless withdrawn in writing.

Please Initial _____

SIGNATURE OF
PATIENT / OTHER X _____ **PRINT NAME** _____ **DATE** _____

IF OTHER,
RELATIONSHIP TO PATIENT _____ **REASON PATIENT**
UNABLE TO SIGN _____