AMBULATORY CONSENT
FOR TREATMENT

(Site)

The Patient Access Representative shall place a check beside the description that describes today’s visit.

☐ EPISODIC CARE and/or TESTING (Consent valid for 1 year)
Consent for Treatment:
Knowing that I require episodic treatment and/or diagnostic testing, I voluntarily consent to and authorize the provision of that treatment and/or diagnostic testing by Seton Family of Hospitals (SETON). I also consent to and authorize the provision of medical care, which includes diagnostic procedures and treatment by my treating physicians, and their associates, assistants, and other healthcare providers, as may be necessary in their judgement and in accordance with any specific consent and/or refusal for treatment signed by me. I acknowledge that no guarantee has been made to me about result or cure. This consent for treatment includes the following kind of episodic care and/or diagnostic testing: ____________________________

This consent will remain in effect for a period of one year from the date I sign it, unless I revoke it in writing before that time. I understand that the consent is in effect until such time that the written revocation is provided to SETON.

☐ SINGLE-VISIT CARE and/or TESTING (Consent obtained with each visit & testing)
Consent for Treatment:
Knowing that I require treatment and/or diagnostic testing, I voluntarily consent to and authorize the provision of that treatment and/or diagnostic testing by SETON. I also consent to and authorize the provision of medical care, which includes diagnostic procedures and treatment by my treating physicians, and their associates, assistants, and other healthcare providers, as may be necessary in their judgement and in accordance with any specific consent and/or refusal for treatment signed by me. I acknowledge that no guarantee has been made to me about result or cure.

This consent will remain in effect for the scheduled date of your care and/or testing only.

FOR ALL CARE and/or TESTING

AUTHORIZATIONS AND IRREVOCABLE ASSIGNMENTS: I agree to be responsible for the payment of the charges that result from the care provided to me. This means that I promise to pay these charges in return for the care and services that will be provided to me.

1. I promise to pay SETON and any physician or other healthcare provider all costs and charges for services provided by SETON or other providers, and I will pay in accordance with bills presented to me.
2. I hereby irrevocably assign and transfer to SETON all right, title, and interest in all benefits payable by and all causes of action against all insurance companies, employee benefit plans, third party administrators, and/or other persons or entities responsible for payment for my care ("PAYORS").
I hereby appoint SETON as my attorney in fact, with power of substitution, to sue or otherwise obtain payment for my medical and health facility care from Payors. This irrevocable assignment and transfer is for the purpose of granting SETON an independent right of recovery against all Payors, but I understand SETON is not required to pursue any such recovery. I authorize all Payors to pay directly to SETON all amounts due for services provided by SETON.

3. I understand that if my insurance requires pre-service certification, it is my responsibility to obtain this pre-service certification. I understand that if I do not obtain this pre-service certification, my insurance may apply a penalty, and this could reduce my level of benefits.

4. I understand that I will be responsible to pay SETON whatever is not paid by my Payors, except when the law provides otherwise.

5. I understand that SETON has the right to take legal action to receive payments assigned to SETON.

6. I understand that there may be professional services from physicians and other healthcare providers during this treatment and that the fees for these services will be billed separately by the providers who supplied the services. I irrevocably assign and transfer my right to receive payment from any Payors to any physicians or other healthcare providers during this admission whose services are billed separately.

7. I understand that SETON does not assume responsibility for personal property including (but not limited to) dentures, hearing aids, glasses, money, and jewelry. I also understand that SETON will not compensate me for lost, stolen, or damaged property.

8. I acknowledge that SETON may release information from this treatment to Payors as necessary (a) to obtain payment for my medical and health facility care and (b) to conduct utilization review, peer review, and quality assurance. I also acknowledge that this information may be released to healthcare providers who may be responsible for my care, for the purpose of securing the services of the providers. I understand that this information will identify me and may relate to my history, diagnosis, treatment, or prognosis; it will also include where applicable psychiatric, alcohol, and drug abuse information and specific laboratory results of HIV (Human Immune Deficiency Virus, the virus that causes AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS).

PHYSICIANS ARE INDEPENDENT CONTRACTORS
I ACKNOWLEDGE AND AGREE THAT PHYSICIANS PROVIDING TREATMENT AND PROFESSIONAL SERVICES TO ME AT SETON, INCLUDING BUT NOT LIMITED TO RADIOLOGISTS AND PATHOLOGISTS WHO ARE NOT EMPLOYEES OR AGENTS OF SETON, BUT RATHER ARE INDEPENDENT CONTRACTORS WHO EXERCISE THEIR OWN PROFESSIONAL JUDGMENT WITHOUT CONTROL BY SETON. AS INDEPENDENT PRACTITIONERS, THEY MAY CHARGE SEPARATELY FOR THEIR SERVICES. PHYSICIANS MAY BE IN-NETWORK OR OUT-OF-NETWORK TO MY HEALTH PLAN.

HIV TESTING AFTER AN ACCIDENTAL EXPOSURE
In the course of care and treatment at SETON, healthcare workers may be accidentally exposed to a patient’s blood or body fluids. Communicable diseases, including HIV virus that causes AIDS, are known to be transmitted through accidental exposures to blood and other body fluids. I understand that, in the event a healthcare worker is exposed to my blood or body fluids during my care, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

CERTIFICATION
I certify that I have read this form (or this form has been read to me). I understand and agree to the above terms and conditions. This form has been explained to me, and I certify that I understand its contents.

☐ I have been given a copy of "Patients Rights, Responsibilities and Healthcare Choices".
☐ I have been given a copy of the HIPAA Privacy Notice.

Signature of Patient/Parent/Legal Representative: ____________________________

Date: ____________________________

Patient is _______ a minor _______ unable to consent because: ____________________________

My relationship to the patient is: ________________ and I have signed this consent on his/her behalf.

Witness: ____________________________