PORTER MEDICAL CENTER
General Consent for Treatment
Emergency Department

_____
Print Patient Name

_____
Print Patient Date of Birth

I understand that this General Consent for Treatment/Care applies to Porter Medical Center, Inc., and its affiliated entities, divisions, programs, departments and units, (referred to in this form as the "Medical Center".)

1. Consent for Treatment/Care

I consent to treatment and care by the Medical Center and by their physicians, employees and/or authorized agents of the Medical Center as they judge is in my best interest. This may include routine diagnostic, radiology and laboratory procedures, photographs and/or recordings taken to help with a diagnosis and/or treatment of a condition, and medication administration. I acknowledge that no guarantees have been made as to the effect of such treatment and care on my condition. I assume responsibility for personal property brought with me.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment. This understanding includes that no research or experimental procedures may be done without my knowledge and consent.

I hereby authorize the Medical Center to dispose of, at their convenience, any specimens or tissue taken from my body during my visit.

I understand that consent is being given in advance of any specific diagnosis and/or treatment and intend this consent to be continuing in nature even after a specific diagnosis has been made and/or a treatment recommended.

_____ Date: ____ /_____ /_____ Time: _____
Patient Signature (or Legal Representative)

_____ Date: ____ /_____ /_____ Time: _____
Witness

_____ Date: ____ /_____ /_____ Time: _____
Second Witness (when authorized by phone)

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2. Authorization to Release Information

I hereby authorize the Medical Center to use and/or disclose my health information for purposes related to treatment, payment for care (subject to Paragraph 4 below) and/or health care operations.

3. Authorization to Pay Benefits to Provider

I hereby authorize payment of benefits to the Medical Center. I understand that I am financially responsible for any charges not covered by this authorization. In consideration for the services to be rendered, I individually obligate myself to pay the account of the Medical Center in accordance with the regular rates and terms of the Medical Center. If I am entitled to health care services under any insurance policy (including automobile no-fault and workers compensation) from any person or organization which may become liable to me to provide such benefits, I assign such benefits to the Medical Center. In the event of non-payment, I agree to pay all reasonable costs of collection, including attorney fees.

4. Assignment of Insurance Benefits and Release of Information (Check One)

☐ I authorize direct payment to the Medical Center of any private or government insurance benefits otherwise payable to me or on my behalf, at a rate not to exceed the Medical Center's standard charges. I understand that payment to the Medical Center, pursuant to this authorization, by an insurance company shall discharge said insurance company of any obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not paid by this assignment, except as otherwise provided for in any separate agreement between the Medical Center and insurance company.

☐ I **do not** authorize the direct payment of insurance benefits or the release of medical information to insurers and **acknowledge that I am assuming full responsibility for all charges associated with this visit.**

5. Consent to Wireless Calls, Texts and E-Mails

I consent to receive calls, texts and e-mails from the Medical Center, its agents or its representatives at the numbers and e-mail address I provided during registration intake for the following purposes: appointment reminders, general health reminders, servicing my account, collecting amounts due and patient experience feedback. Messages may be generated and sent using an automated notification system. Messaging may be prerecorded and delivered. I understand that I am not required to provide this consent in order to receive healthcare services. I understand that message and data rates may apply. I understand that I have the right to revoke this consent using any reasonable method including orally or in writing. I further understand that by revoking this consent, my Patient Portal access will no longer be active.

This form has been fully explained to me and I understand its content and significance.

I certify that I have read the foregoing, received a copy of this document if requested, and I am the patient or the patient's legal representative.

_____Date: ____ /_____ /_____ Time: _____
Patient Signature (or Legal Representative)

_____
Printed Name If Legal Representative - Relationship to Patient

_____Date: ____ /_____ /_____ Time:_____ _____Date: ____ /_____ /_____Time_____
Witness Second Witness (when authorized by phone)

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AUTHORIZATION FOR RELEASE OF INFORMATION WHEN CLAIMING A WORK RELATED INJURY OR OTHER OCCUPATIONAL CARE/SERVICES

I hereby authorize the Medical Center to release the following information from my medical records concerning my work related accident to my Workman's Compensation Carrier.

Date of Injury: ____ / ____ / _____

_____Date: _____ /_____ /_____ Time:_____
Patient Signature (or Legal Representative)

_____ _____
Printed Name If Legal Representative - Relationship to Patient