Consent for Treatment, Financial Responsibility, Privacy Practice, and Patient Rights

I consent to medical examination, laboratory procedures and other studies by designated staff. Girard Medical Center does not discriminate on the basis of race, color, national origin (including individuals with limited English proficiency), sex (including gender identity), age or disability in health programs or activities.

In the event that a healthcare worker is suspected to have been exposed to my blood, I consent to have the hospital determine by serological testing whether or not my blood contains blood borne diseases. I understand that information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those healthcare personnel who become involved in my treatment.

I authorize Girard Medical Center to disclose to the Social Security Administration and to the Centers for Medicare and Medicaid Services or its intermediaries or carriers, and/or my insurance company any information relating to the identity, diagnoses, prognosis, or treatment of myself. I understand the purpose of this disclosure is to facilitate the payment of insurance benefits.

In consideration for services rendered, I hereby assign Girard Medical Center, benefits to which I am entitled under the terms of my insurance policy(ies), and agree to be responsible for services not paid in whole or in part by my insurance company, which I hereby certify is in full force and effect. This authorization will remain in force and effect until revoked by me in writing.

I acknowledge that I was offered a copy of the Girard Medical Center Notice of Privacy Practices and the Girard Medial Center Patients' Rights.

I understand that it is required by law that if I have a condition, such a communicable disease, that I report it to a county, state or national health agency.

I, _______________________________ (guardian name if patient is under 18) certify that I have read the above information. I understand that at any time I may revoke authorization in writing.

Patient Name:____ **DOB:** ______________

Signature: ____ **Date:** _____________________
(Guardian signature if patient under 18)