St. Luke's
MEDICAL GROUP

CONSENT TO TREAT: I consent to the administration of treatment deemed necessary by the Facility, my attending physician, and any other health care professionals responsible for my care. In any event, that any of my caregivers is inadvertently exposed to my blood and I am unable to give consent within the time for initiation of prophylactic treatment, I consent to human immune deficiency virus screening. I understand that those Health Care Professionals who are not employees or agents of the Facility are independent contractors. They have been granted the privilege of using the facility for the care and treatment of patients. I recognize that as such they are not subject to the supervision or control of the Facility with respect to treatment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures, or examinations while in the facility.

I consent and authorize release of information needed to secure payment/ I authorize that all benefits paid by my insurance company be paid directly to St. Luke's Medical Group, and understand that I am financially responsible for all charges incurred that are not covered by my insurance. The patient/guarantor(s) acknowledge and agree that if the account is forwarded to an outside collection agency a collection fee of 10% will be added to the principal of all unpaid delinquencies. If the account is referred to an attorney, the patient will be responsible to pay all reasonable attorney's fees and court costs.

ANY REVISIONS OR ALTERATIONS OF THIS DOCUMENT WILL NOT BE ACCEPTED, AND ANY SUBSEQUENT TREATMENT PROVIDED WILL NOT BE DEEMED A WAIVER OF ANY OF THE FINANCIAL RESPONSIBILITY TERMS.

In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and other health care providers and/or organizations who will be providing subsequent monitoring of care or treatment in connection with care provide by the St. Luke's Medical Group.

I acknowledge that I have read and understand its contents fully and, as applicable, that I have received and read a copy of the Important Notice to Medicare Beneficiaries. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____

Signature of Patient (Applicant) or Legal Representative Date Time

CONSENT TO TREAT/ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____

DOB: _____

Created 9.18.2021
Approved by Quality Committee 10.13.2021