Chambers County Public Hospital District #1

What You Need - Where You Are

Patient's Printed Name: _____ Patient Number: _____

GENERAL CONSENT FOR OUTPATIENT DIAGNOSIS, CARE, AND TREATMENT:

On an ongoing basis, I request, consent, and authorize CCPHD #1 to perform diagnostic and therapeutic tests and procedures and provide general care and treatment as determined necessary and/or ordered by those healthcare professionals involved in my care. This includes, but is not limited to, the performance of physical examinations and x-rays or other radiographic procedures, as well as the taking of blood, tissues, fluids, or other bodily samples. I also consent and authorize CCPHD #1 to examine, use for the purposes for which they were provided, store, and dispose of any blood, tissue, fluids, or other bodily samples in accordance with legal requirements and customary procedures. I understand I may ask my healthcare providers about my care, treatment and procedures at any time and I am encouraged to do so.

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS:

I understand I am financially responsible for all of the charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government healthcare program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize CCPHD#1 to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make payments directly to CCPHD #1 in response to these bills or claims. The undersigned assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to CCPHD#1 of all insurance (Medicare, Medicaid, Group, Indemnity, Workers Comp and MVA) benefits otherwise payable to or on behalf of the patient for this hospitalization or outpatient services.

CONSENT AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION:

CCPHD #1 maintains health records in electronic and other forms. These records describe, among other things, my past and current health status, including the diagnoses of any illnesses and conditions, the nature and results of examinations and tests, treatment provided, and any plans for care or treatment. In addition, these records include billing, social, and other identifying information and may include sensitive information such as genetic testing results, HIV/AIDS status, and drug or alcohol use (all of which is referred to as my "Health Information"). I consent and authorize CCPHD#1, when necessary for my treatment, payment of my bills, or CCPHD#1 business operations, to release and exchange my Health Information. I also consent and authorize CCPHD #1 to release and exchange my Health Information with other healthcare professionals and organizations involved in my care and with business associates that CCPHD#1 have contracted for the same reasons. I also hereby acknowledge that I have received a copy of the Notice of Privacy Practices and have been given information and instructions regarding my Patients' Rights for this facility.

ANY QUESTIONS I HAD ABOUT THIS CONSENT FORM HAVE BEEN ANSWERED. I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SET FORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT IN WRITING, WHICH I MAY DO AT ANY TIME.

Signed: _____ Date: _____
(Patient or Authorized Representative)

Relationship of Authorized Representative: _____
(For example, Parent, Guardian, or Healthcare Agent)

Reason Patient is Unable to sign:_____

Witness 1:_____ Witness 2:_____