GENERAL CONSENT FOR MEDICAL TREATMENT

CONSENT FOR TREATMENT: I voluntarily consent and authorize for such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications by employees and authorized agents of Borrego Health including all affiliated physicians, dentists, nurse practitioners and physician assistants, nursing staff and other ancillary providers, as may be considered necessary or advisable in their professional judgment. I am aware that the practice of medicine is not an exact science and further acknowledge that no guarantees have been made regarding the effect such treatments may have on any medical condition.

TELEHEALTH SERVICES: Certain healthcare services may be provided to me by a telehealth or telecommunications system that allows my provider to view my condition and provide me with treatment directly when I am off site. I am entitled to receive a description of the risks, benefits and consequences of Telehealth Services and a description of my privacy rights as they relate to Telehealth Services. I have the right to terminate Telehealth Services at any time. I may access copies of all transmitted health information. My information will not be disseminated to other entities without my consent. If treatment is provided using an asynchronous system, I have the right to request and receive interactive communication with my provider within 30 days of my request.

RIGHT TO REFUSE TREATMENT: I understand that I have the right to make informed decisions regarding all care and treatments, and that I may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments.

TEACHING PROGRAMS: Borrego Health participates/contracts with training institutions for teaching medical students, interns, residents, healing arts students (i.e.: nursing, hygienists, x-ray technicians, dental assistants) and post-graduate students. I understand that these trainees may participate in the care provided under the supervision of qualified and licensed personnel.

RELEASE OF INFORMATION: I authorize Borrego Health employees and affiliates to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payers including employers, health service plans or worker's compensation carriers.

_____I acknowledge having received the Notice of Privacy Practices which outlines which health information may be used or disclosed.

_____I consent to such disclosures as delineated in the Notice and understand that this may include information related to HIV/AIDS, behavioral health services and treatment for alcohol and/or drug abuse.

CONSENT TO VERIFY PATIENT MEDICATIONS: I further authorize Borrego Health to check and verify my previous and current prescription medication history for the purpose of appropriate consideration of new medication and continuity of care. I am informed and acknowledge that this prescription medication check will be conducted by a third party administrator (Pharmacy Benefit Manager) whom Borrego Health contracts to provide such services.

ASSIGNMENT OF HEALTH BENEFITS: I authorize and instruct the insurance carrier to make payment directly to Borrego Health for any medical, dental or vision benefits otherwise payable to me or my guarantor as payment toward the total charges for professional services rendered. I understand that insurance co-payments, co-insurance and non-covered services are my or my guarantor's financial responsibility.

FINANCIAL AGREEMENT: I agree to pay, whether signing as a patient or representative of the patient, the charges incurred at Borrego Health in keeping with the established fee schedule. I understand that if I am a member of a Health Maintenance Organization (HMO) and have not secured authorization for payment of services, I will be held financially responsible for all non-covered services. I also understand that I am responsible for any balance owed and that a cash deposit will be required for patients not otherwise approved for the sliding fee discount program or other public benefits.

ADVANCE DIRECTIVES: Adults 18 and older have the right to: (a) give direction about their future medical care or (b) designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I understand that information about advance directives is available to me upon request. I have executed an Advance Directive ☐ YES ☐ NO *(If yes please provide us with a copy)*. I would like further information. ☐ YES ☐ NO

Patient:

_____
Print Patient Name

_____ _____
Signature Date

Parent/Legal Guardian:

_____
Print Parent/Guardian Name

_____ _____
Signature Date

Witness:

_____ _____
Print Witness Name Date

Last Revised 8/1/2019