

**GENERAL CONSENT FOR TREATMENT**

I, the patient, or his or her representative, recognize the need for medical and hospital care, authorize Reid Physician Associates, Inc., its health care employees, allied health personnel and physicians to render such routine non-invasive medical/surgical care, tests, procedures, drugs and other services and supplies under the general and specific instruction of the physician. This form is to provide authorization for "routine" services only and not for complex diagnostic or therapeutic procedures. Except for emergency or extraordinary circumstances, it is my understanding that additional consents will be obtained by the treating physician if more invasive services are to be performed.

I understand and am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantee has been made to me as to the result of treatment or examination.

I understand that it is my right to consent, or to refuse consent, to any proposed procedure or therapeutic course.

**RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS**

I, the patient, or his or her representative, authorize my physician to release information from my medical record to my insurance carrier(s), and/or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

**FINANCIAL AGREEMENT**

I, the patient, or his or her representative, recognize that I have read, understood and received a copy of the Reid Physician Associates Financial Policy. I understand and agree, regardless of my insurance status, I am responsible for the balance of my account. In addition, I designate your office, employees, and agents as my representative to file grievances in accordance with Indiana Code, Title 27, Chapters 8 and 13.

**PRIVACY PRACTICES**

I, the patient, or his or her representative, acknowledges that I have received a copy of Reid Physician Associates, Inc., an Affiliated Covered Entity of Reid Hospital and Health Care Services, Notice of Privacy Practices. This office may ask to take your photograph for identification purposes only upon registration. You may choose to decline.

I hereby certify that the information I provided on this form is true and accurate, I have read and understand the statements contained on this form, and I have received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient / Responsible Party Signature

\_\_\_\_\_  
Date

**MEDICARE/MEDIGAP AUTHORIZATION (if applicable)**

I request that payment of authorized Medigap and/or Medicare benefits be made either to me or on my behalf to \_\_\_\_\_ *(name of practice/provider)* for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to \_\_\_\_\_ (name of Medigap insurer) and/or the Center for Medicare and Medicaid Services any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient / Medicare Beneficiary Signature

\_\_\_\_\_  
Date

**CONSENT FOR MEDICAL TREATMENT OF A MINOR (if applicable)**

I (we) the undersigned parent, parents, or legal guardian of \_\_\_\_\_ a minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of \_\_\_\_\_ a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any restrictions: \_\_\_\_\_

\_\_\_\_\_  
Parent or legal guardian signature

\_\_\_\_\_  
Date