MY CONSENT FOR MEDICAL TREATMENT AND BILLING

I consent to medical treatment which may be performed during the visit and for ongoing medical care as a patient of Chugachmiut, including emergency treatment of services, which may include, but are not limited to: laboratory procedures, x-ray examinations, medical and/or surgical treatment and/or procedures, anesthesia and/or medical services rendered under the general and special instructions of the patient's physician, healthcare provider or surgeon.

I understand that:

A) It is customary, except in emergencies or unusual circumstance, that major procedures are not carried out until the patient has discussed them with the physician or other health professionals and has agreed to the procedure(s);
B) Each patient has the right to refuse any proposed procedure(s) and/or treatment(s);
C) No patient will be involved in any research or experimental procedure(s) without his/her full knowledge and consent; and
D) I understand that no guarantee has been made to me as to the result or cures that may obtained from examination or treatment.
E) I understand that Chugachmiut is a teaching facility and that resident physicians "physician in training", medical students, nursing students and other health professional students may be involved in my care. I recognize that these residents and students are supervised by experienced staff. My primary physician and/or healthcare provider have full authority and responsibility for my care. I understand I may refuse care by any resident or students at any time, and that such refusal will not result in any reduction of the quality of care provided.

In the event that a healthcare worker has an exposure to my blood or body fluids during the course of my care at Chugachmiut, I hereby give my consent to be tested for the presence of communicable diseases that may cause risk to the healthcare worker. The results of these tests will be retained with my confidential medical information. I will not be charges for the testing, and the results will be sent to my primary healthcare provider. I understand that testing will be done through Chugachmiut and that I may contact them with any questions or concerns regarding this issue.

FINANCIAL MATTERS

My Financial Obligation for Services Provided to Me

I understand payment in full is required within thirty (30) days of service. I may be asked to remit in full if my insurance has not paid within the time frame. I may make special payment arrangements if this creates a financial hardship by talking to a billing representative at the clinic or contacting the billing department at 907-334-0106. Should the account be referred to a collection agency or an attorney for collections, I understand I shall pay actual attorney fees and collection expenses.

Upon request, Chugachmiut will make a good faith effort to give the patient, guarantor, resident or client, an estimate of charges using the most current pricing for the same or similar services.

These estimates provide no guarantees or limitation to a person's actual billed charges due to the inability to predict all the services and equipment that may be required to comply with the individual plan of care.

My Authorization for Direct Payment of Insurance Benefits to Chugachmiut

I authorize, whether I sign as an agent or as a patient, direct payment to Chugachmiut any insurance benefits otherwise payable for services related to the visit and ongoing medical care. It is understood that I am financially responsible for all charges not covered by this assignment including those that are excluded from coverage by my insurance carrier.

My Consent to Chugachmiut to Release Information

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Chugachmiut to disclose portions of my record, including medical records, to any person and/or corporation which may be liable to pay for my clinic(s) services.

GENERAL INFORMATION

Safe Environment for Health Care

Weapons or other dangerous objects, illegal drugs, and drugs not prescribed to the patient, by the patient's physician or healthcare provider are not permitted at the clinic(s). The clinic's obligation to provide a safe environment for care must override the individual's right to privacy. Chugachmiut reserves the right to search the patient, guarantor, resident or clients and to confiscate such objects upon reasonable probable cause.

Personal Valuables

I understand that the clinic(s) have advised that I should leave my personal property, money, and valuables at home or with family/friends. I agree that the clinic(s) shall not be liable for any loss or damage to said personal property, money, or valuables and waive all such claims. I understand that the clinic(s) is not responsible for the safekeeping of my personal property, money, or valuables left by me in the clinic(s) public areas or in patient, resident or clients rooms.

By signing my signature, I acknowledge that I have read and understand MY CONSENT FOR MEDICAL TREATMENT AND BILLING regarding treatment for myself or if signing as a parent or guardian, for my minor child or the person for whom I am responsible.

Current Phone Number(s) Printed Patient Name Date of Birth

Signature of Patient Date

Signature of Guardian, Relative or Responsible Party Date