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General Patient Consent

Consent for Services
I request and authorize healthcare services as my physicians, his/her assistants, or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic and laboratory procedures, administration of routine drugs, and other therapeutics and routine medical and nursing care. 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 with respect to such diagnostic procedures or treatments.

I am aware that CMU Health is a teaching facility and that Resident Physicians and Medical Students may be involved with my care under the supervision of a staff physician. I consent to their involvement and participation in my treatment. I consent to the photographing, photo copying, or televising of the operation or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identity is not revealed by picture or text.

Payment Authorization
I authorize CMU Health to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to my dependents and/or myself. I assume full financial responsibility for payment of all services provided to me, including any portion of my bill which is not paid by insurance, workers compensation or any other agency.

Co-Pay Agreement
A $5.00 processing fee will be charged if your co-pay is not paid at the time services are rendered. I understand and authorize this fee.

Acknowledgement of Receipt of Notice of Privacy Practices
I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that CMU Health has the right to change this notice at any time. I have the right to revoke this consent, in writing, at any time, except to the extent that CMU Health has taken action in reliance on this consent. I may obtain a current copy at any time by contacting CMU Health or by visiting the website at https://www.cmuhealth.org/Patients/Pages/Policies.aspx.

Acknowledgement of Receipt of the Patient-Centered Medical Home Patient-Provider Agreement
I have received a copy of the Patient Centered Medical Home (PCMH) Patient-Provider Agreement, which describes my responsibilities as a patient and those of my CMU Health care team. I understand my responsibilities.

Date: ________________________

Patient Name (print): ____

Parent/Guardian Name (print): ____

Parent/Guardian Signature: ____

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Shared Protected Health Information (PHI)

☐ **DO NOT** share my health information (excludes HIPAA-permitted uses/disclosures)

☐ You may share my health information with the following people:

______________________________________	________________________
(Print Name Clearly)	(Relationship to Patient)
______________________________________	________________________
(Print Name Clearly)	(Relationship to Patient)
______________________________________	________________________
(Print Name Clearly)	(Relationship to Patient)

Phone Messages (Check all that apply)

☐ CMU Health may leave a callback message or appointment reminders on the answering machine/voicemail attached to my phone number

☐ Send text message appointment reminders to my phone

Phone Number ______________________________ Patient Initials __________

I have read or had read to me this consent. I have had the opportunity to ask questions and have these questions answered.

______________________________________	____________________
(Print Patient's Name)	(Date of Birth)
______________________________________	____________________
(Signature of Parent/Legal Guardian)	(Today's Date)
______________________________________	
(Relationship to Patient)	

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Parents of Guardians of Minor Patients:

CMU Health understands there are times when a parent or guardian is unable to attend a minor's appointment. Completing this section will allow CMU Health to treat your minor if you are unable to attend his or her appointment.

____ (Print Patient's Name)

_________________________ (Date of Birth)

____ (Signature of Parent/Legal Guardian)

_________________________ (Today's Date)

____ (Relationship to Patient)

Please indicate below who is approved to accompany your minor if you are unable to attend the appointment (individuals must be 18 years or older)*:

Name: ___________________________ Relationship: _________________ Your Initials: _______

Name: ___________________________ Relationship: _________________ Your Initials: _______

Name: ___________________________ Relationship: _________________ Your Initials: _______

*I understand that by signing this form, I am allowing my child's protected health information to be shared with the above-named individual(s) during my child's visit.