



1COTX

MY CONSENT FOR MEDICAL TREATMENT AND BILLING

I consent to the procedure/care which may be performed during this visit, including emergency treatment or services, which may include, but are not limited to, laboratory procedures, toxicology screening, x-ray examination, medical and/or surgical treatment and/or procedures, anesthesia and/or hospital service rendered under the general and special instructions of the patient's physician 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 procedures(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 be obtained from examination or treatment in the hospital.

In the event that a healthcare worker has an exposure to my blood or body fluids during the course of my care at a Providence Health & Services Alaska facility, I hereby give my consent to be tested for the presence of communicable diseases that may cause risk to the healthcare worker. I understand that these tests are to ensure that appropriate medical care may be determined for the exposed healthcare worker. The results of these tests will be retained with my confidential medical information. I will not be charged for this testing, and the results will be sent to my primary physician. I understand that this testing will be done through Providence Health & Services Alaska Employee Health Services, and that I may contact them with any questions or concerns regarding this issue.

The Advance Directive

Providence Health & Services Alaska recognizes a properly executed advance directive, declaration/living will or durable power of attorney for health care decisions.

Do you have an advanced directive or durable power of attorney for health care decisions?

Initial: Yes _____ No _____ If yes location: _____

PERSONAL VALUABLES

I understand that the facility maintains a safe to protect the patient's, resident's or client's personal property, money, and valuables, or I have been advised that I should leave my personal property, money, and valuables at home or with family/friends. I agree that the facility or program shall not be liable for any loss or damage to said personal property, money, or valuables and waive all such claims unless those items have been deposited in the facility safe. I understand that the facility is not responsible for the safekeeping of my personal property, money or valuables left by me in the facility public areas or in patient, resident or client room.

**Signature for Consent to Treat & Bill and Receipt of General Information Regarding Treatment & Financial Matters
(General Information Regarding Treatment & Financial Matters is pages 3 and 4)**

Relationship to patient _____

Signature of patient, relative or legal representative

- Patient is a minor _____ years of age
- Patient's medical condition prevents signing

Signature of Witness _____ Date _____ Time _____

NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Signature of Acknowledgement

Date

8561-034 (Rev. 8/12)

PLACE PATIENT ID LABEL HERE



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ROUTING: Original - Medical Records Yellow - Business Office Pink - Patient