

1. CONSENT FOR TREATMENT

I give permission to my physician, and whomever they may select as their assistants, for medical treatment and for reasonable and necessary services including but not limited to, emergency care, administration of approved drugs, nursing care, radiology and pathology, as well as other medical services provided as part of my medical treatment. I am aware that many of the LSU Health System hospitals/clinics are teaching facilities, and, as a result, medical students, nursing students, and other medical career students may be involved in my care.

2. RELEASE OF PROTECTED HEALTH INFORMATION

I understand that the information contained in my medical record is confidential. However, I give permission to this facility and/or my physician(s) to release any and all protected health information to healthcare professionals involved in my treatment and follow up care. I understand this hospital/clinic is part of a system of public hospitals and that if I receive care at more than one LSU Health hospital/clinic, my protected health information will be shared with the healthcare professionals at these facilities.

I understand that this facility participates in joint efforts with the Louisiana Office of Public Health (OPH) to prevent and control infectious diseases (such as measles, flu, HIV, Tuberculosis, and others) and that my protected health information will be shared with OPH as necessary or required by law. Additionally, I understand that this facility reports immunization information to OPH if I receive an immunization.

I also give permission to release of any and all protected health information to my insurance company/provider requesting the information on my behalf for purposes of seeing if I qualify for or can receive reimbursement of expenses for my medical treatment. For a complete list of the situations in which any and all my protected health information may be shared, I will refer to the Notice of Privacy Practices provided to me.

3. FINANCIAL AGREEMENT (ASSIGNMENT OF BENEFITS)

I assign to LSU Health all benefits covering medical expenses. I certify that the information given for Medically Indigent (Free Care) and any application for Medicaid (Title XIX) or Medicare (XVIII) is true and correct. I further agree that, should the amount paid be insufficient to cover the entire medical expense, I will be responsible for payment of any differences. I understand that if I belong to a HMO/PPO, or other Managed Care Contractor, and/or Medicaid Community Care, or a Coordinated Care Network (CCN) for which the provider is not a Primary Care Provider, and I do not have a referral form from my primary care physician, I will be billed in full for services by the hospital and any charges for the Physician and/or the Physician's group. I understand that my physician(s) will send me a separate bill for their services, and that this authorization and assignment also applies to them. If I do not want my insurance company billed, I realize that I must request that change in writing.

4. PATIENT RIGHTS AND RESPONSIBILITIES

I understand that as an outpatient, a copy of the Patient Rights and Responsibilities is available upon request. I understand that upon my first visit to an LSU Health Facility I will receive a Notice of Privacy Practices. On return visits to the facilities this notice is available on request and is also located on the LSU Health Website – <http://www.lsuhealth.org>.

**My signature verifies that I have read and understand this consent.**

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  Patient  Parent

Other \_\_\_\_\_

Guarantor Signature \_\_\_\_\_ Time \_\_\_\_\_ Witness \_\_\_\_\_

(If different from Authorized Signature)

Date \_\_\_\_\_