

**DR. WALTER O. MOSS REGIONAL MEDICAL CENTER
1000 WALTERS STREET, LAKE CHARLES, LA 70607**

Patient Name: _____ Medical Record #: _____

General Consent for Medical Treatment

I authorize and give consent to my physician, and whomever they may designate 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.

Release of Medical Information/Assignment of Benefits

I authorize this facility and/or my physician to release any and all medical information to any third party payer requesting the information for purposes of determining eligibility on my behalf, as well as, to other LSU Health System healthcare professionals involved in my care. I understand that this hospital/clinic is part of a system of public hospitals, and that if I receive care at more than one LSU Health System hospital/clinic, my medical information will be shared among the healthcare professionals at all hospitals/clinics that are part of the system. Additionally, I understand that this facility is required to report certain infectious diseases (such as HIV and Tuberculosis infection) to the Louisiana Office of Public Health (OPH) and that my medical information will be shared with OPH if I am diagnosed or treated for one of these diseases.

I hereby authorize/assign payments of authorized benefits be made on my behalf directly to said provider(s), clinics, including but not limited to any of the LSU Health System hospitals and physicians professional staff involved in my care.

Verification of Information

I certify that the information given in applying for Medically Indigent (Free Care) and in any application for Medicaid or Medicare is true and correct. I understand that the information received will be verified for accuracy.

I understand that if I belong to an HMO/PPO, or other Managed Care Contractor, and/or Medicaid Community Care 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 rendered by the Attending Physician's group.

I understand that I am obligated to pay the remaining balance for medical services after third party payer coverage benefits are applied.

If I should be determined ineligible by any third party payer (including Medically Indigent Care); I am obligated to pay for all services rendered.

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

Patient Rights and Responsibilities

I understand that as an outpatient, a copy of the Patient Rights and Responsibilities is available upon request. If admission to the hospital as an inpatient is necessary, a copy of the Patient Rights and Responsibilities will be provided to me.

Signature: _____ Relationship: _____

Guarantor: _____ Policy Holder: _____

Date: _____ Witness: _____ Witness: _____