St.Vincent's MultiSpecialty Group

PATIENT CONSENT FORM

Patient Name:_____ Date of Birth:_____

The undersigned patient or legal guardian acting on behalf of the patient agrees as follows:

CONSENT TO TREATMENT

Authority is granted to St. Vincent's MultiSpecialty Group to render examination, treatment and/or tests to the patient. Such treatment may include but is not limited to:

- **Administration and performance of all treatments**
- **Radiologic evaluations and laboratory tests**
- **Administration of medications or needed anesthetics**

This consent is given in advance of any specific diagnosis or treatment and will remain in effect after a diagnosis has been made and treatment recommended.
This consent will remain in effect until revoked in writing.

FINANCIAL AUTHORIZATION

I understand that I am responsible for all charges incurred through St. Vincent's MultiSpecialty Group and that any copayment is expected at the time of my visit.
I authorize St. Vincent's MultiSpecialty Group to release any information required for payment of applicable insurance.
I authorize my insurance or Medicare benefits to be paid directly to the treating physician and know that I am responsible to pay non-covered and unauthorized services.
I understand that if I need to cancel or reschedule an appointment it is my responsibility to provide 24 hours notice.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Information Practices that describes how medical information about me may be used and disclosed for purposes of treatment, payment and healthcare operations.
I further acknowledge that a copy of the current Notice of Information Practices will be posted in the reception area and that I may request a copy of any amended Notice of Information Practices at each appointment.

_____ _____
Signature of Patient/Legal Guardian **Date**

_____ _____
Print name if not patient **Relationship to Patient**

H16(3/13)