BeverlyCare

CONSENT OF SERVICES

1. MEDICAL CONSENT:
I, knowing that I, have a condition requiring medical care, do hereby voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by my physician, his/her assistants, or his/her designees, including hospital/clinic personnel, as is determined necessary in his/her judgment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations at BeverlyCare. This consent is designated to cover all procedures at the clinic which do not require a specific consent form. ***Initials*** _____

2. AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION:
I hereby authorize BeverlyCare to furnish to the insurance carrier(s) or their agents such information as it or they might need to request concerning my present treatment in the hospital or clinic. I also authorize BeverlyCare to provide my insurance carrier verbal/written communication, reports or other data prepared by BeverlyCare personnel concerning my present treatment. I also authorize BeverlyCare the request or transfer of medical information to or from the health care provider(s) or facility that will provide continuation of my health care. A photocopy of this authorization shall be considered as valid as the original. ***Initials*** _____

3. ASSIGNMENT OF BENEFITS:
I hereby authorize and assign and transfer to BeverlyCare all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to BeverlyCare of all insurance and health plan benefits payable for these outpatient services. I agree that the insurer or plan's payment to BeverlyCare pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by BeverlyCare to perfect, confirm or validate this assignment. ***Initials*** _____

4. CONFIDENTIALITY:
I understand that BeverlyCare will endeavor to protect the confidentiality of my medical records; however, the clinic shall not be liable by reason of its release of the records or any part thereof when responding in good faith to an apparent valid request. I also understand that I may review and copy my medical records at my own expense and that this review shall take place in the Medical Records Department during regular business hours. ***Initials*** _____

5. TELEMEDICINE CONSULTATION:
Telemedicine involves the use of audio, video or other electronic communication to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physician examination of you may take place and video, audio, and/or photo recordings may be taken.
Initials _____

6. EDUCATIONAL CONSENT:
BeverlyCare is a facility that may participate in the training of physicians, medical students, student nurses and other health care personnel. I agree that they may participate in my care to the extent deemed appropriate by the Medical Staff or clinic personnel and I consent to the demonstration, observation and admission of treatment or procedures by such persons under the supervision of the members of the medical staff or clinic personnel. ***Initials*** _____

7. CONSENT TO PHOTOGRAPHY / VIDEOTAPING:
I consent to the taking of photographs, videotapes, digital or other images of my medical condition or treatment, and the use of the images for purposes of my diagnosis or treatment, including peer review and education, medical research, or training programs conducted by BeverlyCare. I understand that video cameras may be placed and operated within common areas and public spaces inside and outside of the hospital premises for safety/security purposes, including but not limited to parking lots, waiting areas, hallways, etc. ***Initials*** _____

8. FINANCIAL OBLIGATIONS:
Notwithstanding section (3), Illegal representative agree to promptly pay all medical bills in accordance with the charges listed in the clinic's charge description master and, if applicable, the BeverlyCare's charity care and discount payment policies and state and federal law. I understand that I may review the BeverlyCare's charge description master before (or

after) I receive services from the clinic. If any account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law. In accordance with California law, the patient may apply for discounted care and/or charity care and if patient meets certain financial qualifications based on the federal poverty level, self-pay patient or high medical costs (i.e. annual out-of-pocket expense exceeds 10% of family income). I may request to talk to a financial counselor to determine if I qualify for financial assistance. ***Initials*** _____

9. AUTHORIZATION FOR MEDICATION HISTORY INFORMATION AND E-PRESCRIBE:
BeverlyCare currently participates in the Surescripts system, which allows for electronic prescribing of medications and electronic receiving of prescription benefits and medication history such as past prescriptions and dosages filled from other pharmacies. By signing below, you give permission to e-prescribe and access your information electronically. The collected information is stored in your electronic medical record system (EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms properly and in avoiding potentially dangerous drug interactions. ***Initials*** _____

10. AUTHORIZATION/ACKNOWLEDGEMENT FOR RECEIVING AUTOMATED CALLS:
I hereby consent to receiving text, auto-dialed and/or pre-recorded message calls to my cellular telephone as provided by me, or my representative, to BeverlyCare or its affiliates and their agents including, without limitation, any third party debt collectors. I acknowledge that if my cell phone is the only number provided, or is provided in place of a home or work telephone number, I may receive auto-dialed and/or pre-recorded message calls. ***Initials*** _____

11. ADVANCE DIRECTIVE:
Under federal law, patients have the right to be informed of their rights to make decisions about medical treatment and to make "advance health care directives." BeverlyCare provides written information to patients about the right to make medical decisions. California law allows patients to name someone to make health care decisions on their behalf when they are not able to, under a power of attorney for health care, or to give individual health care instructions by writing an advance health care directive. ***Initials*** _____

Is patient representative able to respond? ☐ No ☐ Yes
Does the patient have an advance directive? ☐ No ☐ Yes, location _____
If no, Advance Directive Informational Brochure provided by _____

I Have Received the Additional Facility Specific Addendum:
_____ **HIPAA – Notice of Privacy Practices** _____ **Patient Rights and Responsibilities**
_____ **Advanced Directives Information** _____ **Other information:** _____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative:

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations and Assignment of Insurance or Health Plan Benefits set forth above.

_____	_____	_____	_____/_____
Print Name of Patient or Financially Responsible Party	***Signature***	***Relationship to the Patient***	***Date/Time***

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____	_____	_____	_____/_____
Print Name of Patient / Parent Guardian / Conservator Responsible Party	***Signature***	***Relationship to the Patient***	***Date/Time***

_____
Print Name/Signature of Witness

Translator: I have accurately and completely read the foregoing document to _____ (name of patient/person legally authorized to give consent) in _____, the patient's or patient's representative's primary language. He/she understood all the terms and conditions and acknowledged his/her agreement thereto by signing this document in my presence.

Translator Name: _____ Signature: _____ Date/Time: _____ / _____

A COPY OF THIS DOCUMENT IS TO BE DELIVERED TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THE DOCUMENT