Consent to Treatment

Patient Name: _____

PennState Health
St. Joseph

Patient MR#: _____ DOB: _____

1. I hereby voluntarily consent to receive medical services at Penn State Health St. Joseph Medical Group and Regional Health Network including diagnostic and therapeutic procedures, examinations, hospital care and medical and/or surgical treatment as deemed necessary or advisable by my physician(s). I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding the result of my treatment or examination in the office or hospital. I am aware that I may refuse any drugs, treatments, and/or procedures offered to me.

2. I hereby authorize Penn State Health St. Joseph Medical Group and Regional Health Network to release all information, including all or any part of my medical records, to my insurance company, employer (Workman's Compensation only), Medicare, Medicaid, Medigap, liability, automobile, or any other fund or third party which may be responsible for payment of benefits on my behalf. I hereby assign and grant to Penn State Health St. Joseph Medical Group and Regional Health Network all rights and interests to which I may be entitled. I authorize payment of any such benefits directly to Penn State Health St. Joseph Medical Group and Regional Health Network.

3. For adult (or eligible minor) patients to receive communications from Penn State Health St. Joseph Medical Group and Regional Health Network, I have provided my **email address for participation in the Patient Portal:** _____. Your Provider is not responsible for the re-disclosure of any information you have received, shared or viewed through the Patient Portal.

☐ I decline participation in the Patient Portal.

4. I agree that I am responsible for payment of Penn State Health St. Joseph Medical Group's and Penn State Health St. Joseph Regional Health Network's established charges currently in effect to the extent that said charges are not covered, allowed, non-referred, non-authorized or paid by my insurance company, Medicare or any other fund or third party payment plan. Payment for non-covered charges, copayments and deductibles will be requested at the time of service. The patient's insurance(s) will be billed but the responsibility to confirm in network participation of the patient's specific insurance plan(s) and product(s) lies solely with the patient. Any charges denied by your insurance due to non-participation are the responsibility of the patient to pay in full. If my account is referred to a collection agency, I agree to pay all legal, collection agency or attorney fees.

5. If I do not cancel my scheduled appointment within 24 hours prior to the date and time of service, I agree to pay a fee in the amount of $25.00.

Dishonored, non-sufficient funds (NSF) checks will be charged back to your account with a service fee of $25.00.

6. I consent to and authorize Penn State Health St. Joseph Medical Group and Regional Health Network to access and review any of my electronic prescription medication history information which may be available through Surescripts Database which will become a part of my medical record.

7. You agree, in order for us to service your account or to collect monies you may owe, Penn State Health St. Joseph Medical Group and Penn State Health St. Joseph Regional Health Network and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

8. I acknowledge that I am in receipt of Penn State Health St. Joseph Medical Group and Regional Health Network's Notice of Privacy Practices.

9. I will provide my current insurance(s) cards at time of service. If the insurance changes, you must notify us immediately. If correct insurance is not presented at time of service and the insurance denies, I agree to pay the full charges.

My signature or verbal permission below indicates I have read and fully understand this document. I hereby accept and agree to the terms of this Consent to Treatment Form.

_____ _____

Patient, Legal Representative/Guardian or Emancipated Minor ***Date***

☐ ***Patient unable to sign due to condition. Verbal permission given.***

_____ _____

Parent or Legal Representative/Guardian of Minor Child ***Date***

Verbal Permission to Treat Minor by: _____ _____

Parent or Legal Representative /Guardian of Minor ***Date***

_____ _____

Witness to verbal permission ***Witness to verbal permission***

Effective date: 1/1/17