Patient Consent for Treatment – Mary Lanning Clinics

1 **CONSENT**: I consent to medical care for myself (and my newborn child in maternity cases), including all examinations, tests, blood transfusions, photographs, therapies and other procedures which my physicians and their assistants or clinic personnel deem necessary or appropriate. Any tissue removed may be disposed of by Mary Lanning Healthcare in its customary manner. I acknowledge that no guarantees have been made as to the results of such hospital and medical care. I understand that I have (or the patient has) the right to refuse treatment and that my signature below is not a consent to any non-routine or non-emergency procedure. The physician and/or a member of the nursing staff may ask me to sign a form consenting to special medical or surgical procedures. Patients are encouraged to insist on any additional information necessary to make an informed decision to consent or refuse treatment. In the event a health worker has direct contact with my blood or body fluids, the clinic must evaluate whether the worker has been exposed to any infectious diseases with the test results provided to those with a need to know. I acknowledge that the physicians and certain other practitioners providing services to me are independent contractors, and are not employees or agents of the clinic.

2. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign to Mary Lanning Healthcare, for services provided by Mary Lanning Healthcare and its employees or others working under contract or arrangement with Mary Lanning Healthcare, all coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to Mary Lanning Healthcare. I agree that Mary Lanning Healthcare directly receive benefit payments and discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payment or other sources may be applied to any other account owed by me of the undersigned. The benefits assigned include, but are not limited to, all benefits for all medical and hospitalization insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid and CHAMPUS, benefits payable by alternative delivery systems such as HMOS and PPOs or arising from worker's compensation or occupation disease claims; and proceeds to which I am, or my estate is, entitled because of any judgement, settlement, or other claim or cause of action for damages against any person or organization if I was or am injured. This assignment may not be revoked as to services provided during this clinic visit or course of diagnosis and treatment.

3. **FINANCIAL AGREEMENT**: I agree to promptly and fully pay all charges for services and supplies provided by the clinic, physicians, and others providing services in accordance with their regular rates and terms. I hereby personally obligate the patient, and also personally obligate myself if signing as the patient, the spouse of the patient, the parent of a minor patient, or the legal guardian of a patient, for payment of all such charges at the regular rate to the extent not covered by insurance, and agree to pay any charges which, for any reason, are not promptly paid by insurance. I authorize Mary Lanning Healthcare to obtain one or more credit reports on the patient and/or me. I understand that it is my responsibility to obtain any prior approvals required by an insurer, and to take all other steps to qualify for insurance coverage; I will determine whether my insurer requires pre-certification before I receive clinic services. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder.

4. **RELEASE OF INFORMATION**: I understand that Mary Lanning Healthcare may disclose all or any part of my medical record to any person or entity which may be responsible for any portion of the charges incurred. I understand that Mary Lanning Healthcare may release at any time the medical records from this clinic visit to any physician or other health care professional (and their staff) who may require health information in connection with my current or subsequent health care.

5. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE**: I was given the Mary Lanning Healthcare Notice of Privacy Practices:
   Check appropriate box: ❑ during this hospital admission/hospital outpatient visit
   ❑ during a previous Mary Lanning Healthcare encounter

6. **REVOCATION**: My consent for routine care shall be ongoing and remain valid unless I revoke it, which I may do at any time, verbally or in writing.

7. **NEBRASKA HEALTH INFORMATION INITIATIVE (NeHII)**: Mary Lanning Healthcare participates in NeHII, which is sponsored by Nebraska health care providers and insurers, and was developed to share information so that participating doctors can quickly view my health information when caring for me. I acknowledge that I have been provided information on NeHII and my information will be included in NeHII unless I choose to opt out.

8. **ACKNOWLEDGEMENT OF FINANCIAL POLICY:** I was given the Mary Lanning Healthcare Clinics Financial Policy.

9. **MARY LANNING HEALTHCARE PORTAL CONSENT:** I understand that the email address I provide during my visit/admission will be used by Mary Lanning Healthcare to send me an invitation and instructions on how to create a unique registration that I can use to access my medical records through the online Patient Portal. I also understand that if the email address I provide is a shared email address (for example, if I share the same email address with a spouse or other family member), or if others have access to my email account, they may also be able to access to the Patient Portal invitation and may be able to create a unique registration and view my medical records available through the Patient Portal. I understand that I am responsible for anyone who may see my information because my email address is a shared email address or I have given access to my email account to another person. Details and privacy recommendations can be found in the Mary Lanning Healthcare Patient Portal Terms of Use at www.marylanning.org.

I Have Read Or Had Read To Me The Contents Of This Form. I Understand And Accept Its Terms. I Have Had The Opportunity To Ask Questions And Any Questions I Asked Have Been Answered To My Satisfaction. If Signing For Someone Else, I Represent That I Have Legal Authority To Do So.

Date:_____ **Time:**_____ ❑ AM ❑ PM Patient Account #_____

Signed:_____ _____
Patient or legal representative Relationship if other than patient

Witness:_____

Mary Lanning HEALTHCARE

MOM-917

Patient Authorization for Treatment - Free Standing Clinics (not hospital departments)

Admissions Consent

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