Consent and Acknowledgment of Treatment and Services

March 3, 2017

GENERAL CONSENT AND ACKNOWLEDGEMENT FORM

1. General Consent to Treatment: By signing below, I authorize the health care providers at **Cayuga Medical Associates** to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services, or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, procedures, or tests. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, side effects, or reasonable alternatives to the procedures or tests. This General Consent to Treatment form does not take the place of an informed consent form for a particular procedure or test.

a. Right to Refuse Treatment: I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my treating health care provider(s).

b. Medical Education and Participation of Students and Trainees: I understand that authorized, appropriately supervised students and trainees may observe and assist in my treatment and care, unless I expressly object to their participation in my health care.

I acknowledge and agree that this consent/acknowledgment will be applicable to all visits or instances of treatment by **Cayuga Medical Associates.**

By initialing below, I acknowledge that I have read and understand the above information.

Section 1 TO BE SIGNED ELECTRONICALLY

2. Acknowledgment of Responsibility for Payment: By initialing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from **Cayuga Medical Associates**. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments. Unless I pay personally in full for services, I understand that health information about me may be shared with my health insurance carrier(s) or other third party payers responsible for paying for my health care.

By initialing below, I authorize **Cayuga Medical Associates** to share information about me, with my health insurers, unless I pay personally in full for my services, in order to be paid for the services they have provided. I agree that the patient named in this form (myself or another over whom I have legal authority) is covered by the insurer(s) that I have shared with **Cayuga Medical Associates**, and that I have received no notice of discontinuation of benefits.

I acknowledge and agree that this consent/acknowledgment will be applicable to all visits or instances of treatment by **Cayuga Medical Associates.**

By initialing below, I acknowledge that I have read and understand the above information.

Section 2 TO BE SIGNED ELECTRONICALLY

3. Minors: If you are a minor who consents to health care services on your own behalf, but utilize your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner.

I acknowledge and agree that this consent/acknowledgment will be applicable to all visits or instances of treatment by **Cayuga Medical Associates.**

By initialing below, I acknowledge that I have read and understand the above information.

Section 3 TO BE SIGNED ELECTRONICALLY

4. Notice of Privacy Practices: By signing below, I acknowledge that I have been offered the Notice of Privacy Practices.

Section 4 TO BE SIGNED ELECTRONICALLY