Rev. 11/2024

CONSENT AND CONDITIONS OF TREATMENT
Emergency Responders Health Center - North

Patient Name: ____ Birth Date: _______________

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment of the Patient by **Emergency Responders Health Center** ("PRACTICE") and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care and mental health treatment; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. If PRACTICE personnel suffer from a needle stick or are exposed to blood or bodily fluids, I consent to the testing of Patient for any blood-borne disease for the protection of PRACTICE personnel.

CONDITIONS FOR TREATMENT AT PRACTICE. In consideration for the care and treatment that Patient will receive or has received at PRACTICE, I agree to the following:

1. **Payment.** I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and PRACTICE. I agree to make such payments according to PRACTICE's regular terms of payment. Where appropriate, I agree to submit and cooperate with PRACTICE in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to PRACTICE's policies, including but not limited to reasonable costs of collection, collection agency fees, attorney's fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.

2. **Assignment and Authorization.** I hereby assign and authorize direct payment to PRACTICE of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Practice or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Practice's right to use or disclose protected health information as otherwise allowed by applicable law or Practice's Notice of Privacy Practices.

3. **Billing Practices.** I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. PRACTICE may amend such quotes, and I will be responsible for charges for services actually rendered. I understand and agree that PRACTICE will require payment of all accounts at the time the services are rendered unless PRACTICE has expressly agreed to contrary arrangements. Where insurance is available, PRACTICE will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at PRACTICE.

PERSONS FOR WHOM PRACTICE IS NOT LIABLE. I understand that PRACTICE is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by PRACTICE may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that PRACTICE is not liable for the acts or omissions of non-employees or PRACTICE employees acting outside the course and scope of their duties.

INJURY CAUSED BY THIRD PARTY. Please indicate the following:
[ ] My condition was <u>not</u> caused by the wrongful act or omission of another person.
[ ] My condition <u>was</u> caused by the wrongful actions of the following person[s]:
Name: ______________________________________
Address: ______________________________________

NOTICE OF PRIVACY PRACTICES.
I have received a copy of PRACTICE's Notice of Privacy Practices on this or a prior occasion. [Please Initial]: ___________
I respectfully decline a copy of PRACTICE's Notice of Privacy Practices [Please Initial]: ___________

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

NOTICE OF LATE CANCELATION/NO-SHOW POLICY.
I understand that ERHC requests that appointments be canceled no later than 24 business hours prior to start time (48 hours for Annual Wellness Exams); that unconfirmed appointments may be canceled by ERHC and offered to another patient; and that fees may be assessed for late cancelations or missed appointments. I have been notified that an updated copy of ERHC's Appointment Late-Cancelation/No-Show policy and fees is available upon request, and is posted at erhcnorth.org. [Please Initial] ___________

____ ____________________
(Print Name) (Date)

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(Signature)

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Relationship to Patient/Authority