St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL
Steward

Affix Patient Label Here

STEWARD MEDICAL GROUP PATIENT CONSENT

Consent to Treatment

I consent to general treatment, medical procedures, and medications prescribed by my doctor

Signature: X _____

Financial Policy

I understand my insurance policy is a contract between my insurance company and myself, and that I am ultimately responsible for the entire bill. The only exception to this is an approved worker's compensation claim, and that should my worker's compensation status be reversed, that I am then responsible for the entire bill. I understand that the fees are based on treatment received and have no bearing on outcome. I also understand there may be a charge for appointments missed or cancelled less than 24 hours prior to my appointment time.

I understand this Financial Policy - Signature: X _____

Authorization to Pay for Professional Services Rendered

I hereby authorize payment directly to Steward Medical Group of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company.

I understand this Professional Services Rendered Policy - Signature: X _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Steward Medical Group's Notice of Privacy Practices. I understand that Steward may, at its discretion, change the terms and conditions of this Notice. I understand the content of the Notice and that I will be provided with a copy upon my request.

I have received the Notice of Privacy Practices: Signature - X _____

Note to office staff: If unable to obtain acknowledgement of receipt of Notice of Privacy Practices, please note reason below and include signature:

Reason:_____

_____

Staff Signature and Date:_____