SAPPHIRE
Health & Wellness

Sapphire Health and Wellness Consent Form

AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT: I hereby voluntarily consent to outpatient care from Sapphire Health and Wellness encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Sapphire Health and Wellness' medical Providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Sapphire Health and Wellness to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY: I have received Sapphire Health and Wellness' Notice of Privacy Practices and Patient Rights.

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION: I hereby authorize Sapphire Health and Wellness to access historical prescription drug information.

ACKNOWLEDGEMENT OF PERSONAL PROPERTY: I understand that the Sapphire Health and Wellness shall not be liable for loss or damages of any personal property.

FINANCIAL POLICIES: I authorize Sapphire Health and Wellness to file a claim with my insurance carrier for services rendered. I authorize payment of medical benefits by any insurance carrier to either the Clinic or myself. I understand that insurance is a contract between myself and my insurance carrier. Sapphire Health and Wellness is not a party of this contract. We will bill your insurance carrier as a courtesy to you. In order to properly bill your insurance carrier we require that you disclose all insurance information including primary and secondary insurance cards, as well as, any change of insurance information within 60 days of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. It is your responsibility to determine if your insurance company is contracted with us. If your insurance carrier is not contracted with us, you are responsible to pay any

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portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If your insurance carrier pays you directly, you are responsible for payment and agree to forward the payment to us immediately. All copayments, coinsurances, and deductibles may apply. Copayments are the patient's responsibility at the time services are rendered. If you are uninsured, please note that your account is your responsibility. No patient will be denied emergency treatment due to his/her inability to pay. Discounts for essential services are offered dependent on income and household size as compared to the current federal poverty guidelines. Please inquire for more details. The parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age or older and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party. I understand that hospital services (i.e. laboratory tests and diagnostic images such as X-ray, CT, US, and MRI) are billed separately by the hospital and therefore not included in our charges. Clinic discounts do not apply to hospital bills. The patient will need to contact the hospital regarding charges and payments.

ACKNOWLEDGEMENTS

1. Notice of Privacy Practices: _____I would like a copy ___I have already received this information

2. Patients' Rights and Responsibilities: ____I would like a copy ____ I have already received this information

3. Advanced Directives: _____ I would like a copy _____ I have already received this information

I understand that I may revoke this consent in writing; except to the extent that the organization has already taken action in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me. My signature below indicates that I understand and accept the content of this form.

Signature _____ Date Time _____AM/PM

Patient or Patient Representative Print Name_____

Date of Birth_____ If not the patient: Relationship to Patient _____

Witness_____ Date _____Time _____AM/PM

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