CrescentCare
A Partnership for Life

# General Consent Form

***Consent to Participate***: I authorize providers, contractors, and employees of CrescentCare to provide medical treatment, including but not limited to tests, diagnostic procedures, and labs. I understand that healthcare is not an exact science and acknowledge that no guarantees have been made about my care or outcomes. Telemedicine may be provided, and I am allowed to decline this option.

***Consent to Disclose & Release Medical Information***: I understand that my insurance company and/or their agents may need information to make determinations about payment. I hereby provide authorization to release any information that they deem necessary for payment or quality review to insurance companies, or others acting on their behalf, which are involved with payment for any charges incurred by the patient.

I authorize the release of my health information to staff who are involved in my healthcare now and in the future, and to other institutions for the purpose of my continued care and treatment, including referrals and substance abuse treatment. I authorize CrescentCare and its employees to act as my authorized representatives when providing benefits application assistance.

I authorize CrescentCare to use Health Information Exchanges (HIEs) to share my health records with participating doctor offices, hospitals, labs, and other providers through secure, electronic means so that providers in a routine visit or emergency can access recent information about my health to better treat me. I can opt out of participating in HIEs at any time, though information that has already been shared cannot be revoked. I understand that my consent to participate is not required to receive treatment at CrescentCare.

***Consent for Financial Obligations:*** I authorize CrescentCare to bill my insurer for charges in connection with my diagnosis, care, and treatment. I understand that I am responsible for charges that are not covered by my health insurance or other sources, such as a deductible, co-payment, co-insurance, denied services, or other charges. Patient refunds will be distributed only after all balances are paid. If requested, CrescentCare can provide an estimate of my costs.

***Assignment of Insurance Benefits & Sliding Fee Scale****:* I authorize and instruct my insurance company, health plans, insurers, or any entity responsible for payment of my medical expenses to pay all medical and/or other benefits directly to CrescentCare. For services rendered, I assign to CrescentCare any and all of my rights, interests, and benefits payable under any of my plans or policies, including but not limited to any right to appeal a denial of a claim, any right to bring any action, lawsuit, administrative proceeding, or other cause of action on my behalf. I specifically assign my right to pursue litigation against any and all insurance companies, health plans, defined benefit plans, health insurers, or any entity that is or may be responsible for payment of my medical expenses based upon a refusal to pay charges. CrescentCare offers a sliding fee scale for eligible individuals. If I am referred to an outside provider or lab, I must make payment arrangements with them separately.

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I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

***Communication***: I agree to receive communications from CrescentCare including mail, e-mail, phone calls, or text messages related to billing, care and treatment, appointment reminders, surveys, and account balances. I can opt out of these communications at any time.

***Receipt of Documents****:* I acknowledge receipt of the Patient Handbook, Notice of Privacy Practices, and Controlled Medication Agreement. These documents are available at crescentcare.org.

**My signature acknowledges that I am authorized to sign this document, I understand the information, I was given the opportunity to ask questions, and any questions were answered to my satisfaction.**

Patient Name _____ Patient Date of Birth _____

Signature of Patient (or Authorized Individual) _____