



## General Consent for Treatment and Receipt of Notices

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Patient Name

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MRN#

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Date of Birth

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Phone #

**Authorization for Treatment:** I do hereby acknowledge, agree and give my consent for medical, behavioral health and dental diagnosis and treatment as deemed necessary by Lakeshore Community Health Care (LCHC) as indicated appropriate by my treating provider, their assistants and/or designees. This authorization includes, but is not limited to, routine procedures, outpatient, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this facility. I acknowledge that my care is under the direction of my treating provider and LCHC will follow the instructions of my provider(s) in the position in said care.

**Patient Care:** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well-being.

**Personal Valuables:** I accept full responsibilities for all property in my possession. I understand that LCHC maintains no responsibility for property that is personal and in my possession.

**Assignment of Benefits:** I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to LCHC and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for LCHC. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicaid and any self-pay and /or sliding fee details. A photocopy of this agreement shall be as valid as the original.

**Authorized Representative:** I hereby authorize LCHC and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said facility(s).

**Statement of Responsibility:** I understand that I am financially responsible to LCHC as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical/dental insurance deductibles, co-insurance and out-of-pocket expenses.

**Authorization to Release Information to Insurance Company/Third Party Payer:** I hereby authorize facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this facility, the patient, or a family member for all or part of the facility(s) charge. This facility

will endeavor to protect the confidentiality of my medical records. However, the facility shall not be reliable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release.

**Non-covered Medicare/Medicaid Services:** The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

**Advanced Instructions for Healthcare:** I understand that I may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment LCHC will recognize such instructions in accordance with Wisconsin law and the facility(s) policies if either both Advance Direction statement(s) are provided to the facility(s) so that a copy is filed with any medical record.

**Please list your personal representatives (18 years of age or older\*) authorized to access your health information and/or consent to treatment on your behalf. \*Emancipated minors are exempt from the age restriction.**

Name	Relationship	Address	Phone Number	Consent to Treatment	
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO
				<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Please Initial:**

\_\_\_\_\_ I acknowledge notification of LCHC's Privacy Practices and Patient Rights and Responsibilities.

\_\_\_\_\_ LCHC is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at [www.ochin.org](http://www.ochin.org). As a business associate of LCHC, OCHIN supplies information technology, including **LAKESHORE Health Connect** and related services to LCHC and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by LCHC with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

\_\_\_\_\_ I understand that I may be billed for charges not covered by my co-pay or insurance.

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**Patient Signature/Parent if Minor/Power of Attorney/Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Responsible Party's Signature (if not the same as Patient/Parent)**

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**Insured Signature**