Doctors on Call Patient Registration

GENERAL CONSENT TO TREATMENT

I hereby voluntarily consent to the performance of such diagnostic procedures and/or medical treatment as my physician, non-physician practitioner (PA-C/CNP), their assistants or designees at Doctors on Call may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, specialty referrals, and routine medical care. I authorize my physician(s) or provider(s) to perform other additional or extend services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician/provider and that other personnel render care and services to me according to the physician's instructions.

- I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with regard to results of such diagnostic procedures or medical treatment.
- I understand that samples of body fluids and/or tissues may be withdrawn from me during routine diagnostic procedures, and authorize Doctors on Call to properly dispose of these body fluids.
- I have been informed and understand that an HIV (Human Immunodeficiency Virus- AIDS) test may be performed on me without my consent if a health professional or Doctors on Call employee sustains an exposure to my blood or other body fluid.
- I also understand that to facilitate my medical care, my medical records from different locations where I receive health care can be accessed electronically using a statewide computer network that shares health information. The computer network is compliant with the privacy and security standards of HIPAA and New York State Law.

ASSIGNMENT OF BENEFITS

I hereby assign and request that payment of authorized insurance benefits, including Medicare if applicable, be made on my behalf to Doctors on Call for any medical services provided.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Doctors on Call, the Centers for Medicare and Medicaid Services, any other insurance carrier with whom I have coverage.

Continued >>>

I understand that I am financially responsible to Doctors on Call for any charges not covered by health care benefits, and I am only responsible for any deductible, co-pay or other amounts for services not covered by my insurance. I understand that Doctors on Call agrees to accept the payment made by Medicare and any other insurance coverage as its full charge. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify Doctors on Call of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature below is an acknowledgement that I have read, or have been read, and have received a written copy of the Doctors on Call Notice of Privacy Practices and Individual Rights.

Patient Signature: _____ **Date:** _____

If patient is unable to sign:

Responsible Party: _____

Relationship: _____

Telephone: _____

Address: _____

Signature: _____ Date: _____