Banner Health®

MEDICAL TREATMENT AGREEMENT

Patient's Name:_____ **Date of Birth:**_____

Patient or the patient's legal representative agrees to the following terms of Clinic encounters:

1. MEDICAL TREATMENT:

The patient consents to the treatment, services and procedures which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatments or procedures, or anesthesia.

2. LEGAL RELATIONSHIP BETWEEN CLINIC AND HEALTH CARE PROVIDERS:

The patient will be treated by his/her attending physician or health care providers and be under his/her care and supervision. Physicians and other health care providers furnishing services to the patient, including but not limited to the radiologist, pathologist, are generally not employees or agents of the Clinic. These providers may bill the patient separately for their services. Questions about whether a health care provider is an agent or employee of the Clinic should be directed to Administration during normal business hours.

3. TEACHING PROGRAM:

The Clinic participates in training programs for physicians and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or Clinic employees. These persons in training may also observe care given to the patient by physicians and Clinic employees.

4. RELEASE OF INFORMATION:

The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED INFORMATION) may be released to the following:

A. Healthcare providers or their agents who are providing or have provided health care to the patient; any individual or entity responsible for payment of Clinic's or other provider's charges; to healthcare providers or organizations accrediting the facility or conducting utilization review, quality assurance, or peer review; and to the Clinic's and provider's legal representatives and professional liability carriers.

B. Individuals and organizations engaged in medical education and research, that information may only be released for use in medical studies and research without patient identifying information.

C. Individuals and entities as specified by federal and state law and/or in the Clinic's Notice of Privacy Practice.

D. Patient records of services provided at any Banner facility or Banner Surgicenter may be exchanged among these facilities where necessary to provide appropriate patient care. This Release shall continue for as long as the medical and/or financial records are needed for any of the above-stated purposes.

E. This is an assignment of benefits of my rights and benefits under my insurance. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company.

5. CONTRABAND:

Drugs, alcohol, weapons, and other articles specified as contraband by the Clinic may not be brought onto Clinic premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.

6. PHOTOGRAPHS/TAPED THERAPY SESSIONS:

I understand and agree that a photograph may be taken of me for identification purposes or for other treatment purposes. I further agree that therapy sessions may be taped (audio and/or video taping) and that all photographs and tapes will remain the property of the Clinic. I will not take pictures of Banner staff without their permission.

7. COMMUNICATION:

_____ Okay to call my home and leave a message

_____ Call my home phone but DO NOT leave messages.

_____ DO NOT call my home phone, CALL ONLY this number. ( ) _____ - _____

May we leave a message on this phone? _____ Yes _____ No

_____ DO NOT speak to family members.

_____ Okay to send me my health information by encrypted email. Email Address:_____@_____

I authorize the following individuals to inquire and receive verbal information regarding my care.

1._____

2._____

3._____

(ACTUAL RELEASE OF MEDICAL RECORDS REQUIRES A SEPARATE FORM)

I have received the Notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign the agreement.

_____ _____

Patient / Parent of Minor Child / Court- Appointed Guardian
Patient-Appointed Agent / Statutory Surrogate
Please circle the correct title

Witness:

_____

Date: **Time:**