UofL Physicians

GENERAL CONSENT FORM

PATIENT NAME: _____ Date of Birth: _____

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims.

Initials: _____

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions.

Initials: _____

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient. Initials: _____

Cell Phone Calls/Text and Emails. As a service to our patients, we provide a courtesy appointment reminder calls/text and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number. By providing your email address you acknowledge that you may receive health care surveys and other health care related communications. You understand this is not to be used for provider communication and that email is not secure and can be intercepted and used by unauthorized persons.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities _____ Declined_____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices _____ Declined_____

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only_____ Declined_____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature **Date**

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____