

PSS Oral & Maxillofacial Surgery

Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed by my physician or his/her designee. I understand that Pediatric Surgical Subspecialists includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to the Pediatric Surgical Subspecialists until revoked by me in writing.

2. Consent to Release Information

I acknowledge that Pediatric Surgical Subspecialists may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Pediatric Surgical Subspecialists.

I acknowledge and consent to allow Pediatric Surgical Subspecialist to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to Pediatric Surgical Subspecialist all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Pediatric Surgical Subspecialist are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Pediatric Surgical Subspecialist on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by Pediatric Surgical Subspecialist or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payor for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of Privacy Practice

I acknowledge receipt of the "Notice of Privacy Practices" from Pediatric Surgical Subspecialist.

Patient Printed Name

Patient Date of Birth

Patient/Responsible Party Signature

Date

Witness

Date