ENSIGN Family Medicine, LLC

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Patient Consent Form

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication(s)
- Performance of diagnostic procedures/tests
- Taking and utilizing of cultures and specimens
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis had been made and treatment recommended. **The consent will remain in full force until revoked in writing.**

I, the undersigned responsible party, acknowledge that Ensign Family Medicine may use my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the authorization of a all treatments, the administration of any needed anesthetics, the use of prescribed medications, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgement of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Ensign Family Medicine of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to employer or designee. I understand that I am financially responsible for the charges not covered by this authorization. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any physician and their offices or insurance companies participating in the care of treatment for the patient.

I also understand that my information will be released to county, state, and federal health agencies and organizations as required by law.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after specific diagnosis has made and treatment recommended. The consent will remain in force until revoked in writing. This consent also includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given the Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Officer. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient Name (PLEASE PRINT) **Date of Birth**

_____ _____

Signature of Patient or Responsible Party **Date**