Health Center
at Touro University Nevada

General Consent to Treat / Patient Authorization
Acknowledgement of Benefits Release

The following are the conditions for services provided by Touro University Nevada Health Center for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/We voluntarily consent to medical treatment and diagnostic procedures provided by Touro University Nevada Health Center and its associated physicians, clinicians, and other personnel. I/We consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/We am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, and further medical treatment. To include information referring to psychiatric care, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/We also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law. I/We fully understand that, as part of a teaching institution, information may be collected from the patient encounter or chart in order to collect data. I/We understand that personal health information may be used or disclosed for the purposes of carrying out treatment, evaluating the quality of services proved and any administrative operations related to treatment or payment. I/We understand that I/we have the right to restrict how the personal health information is to be used and disclosed for treatment, payment and administrative operations if I/we submit a written request. I/We understand that each request will be considered for restriction on a case-by-case basis.

ASSIGNMENT OF INSURANCE BENEFITS

I/We guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Touro University Nevada Health Center. I/We understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/We understand that Touro University Nevada Health Center can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection, I/we shall pay all collections fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/We have provided all necessary information for proper assignment of Medicare benefits.

ROUTINE PHYSICAL APPOINMENTS

I understand a routine physical appointment cannot be accompanied with any health complaints or abnormalities. I understand that if any complaints or abnormalities are addressed with the physician the visit may not be billed as a routine physical and I may be responsible for all copays, deductibles or co-insurance costs associated with the visit.

_____***Initials***

LAB DISCLAIMER

It may be necessary to perform or request lab work (cultures, pap smears, biopsies, lab work, etc.). Our office may send you directly to the Lab of your choice. Our office may send out a specimen to a Lab of the Physician's choice, but will consider your insurance carrier. Each test may have more than one fee depending on the complexity. Your insurance carrier may not cover certain tests. It is your responsibility to know your benefits. We cannot change any coding (CPT Procedure Codes or ICD-9 Diagnosis Codes) to conform to your plan's coverage or benefits.

_____ ***Initials***

WORKER'S COMPENSATION PATIENT RECORDS RELEASE AND AUTHORIZATION

I understand that Nevada Worker's Compensation law provides that written information pertaining directly to a worker's compensation claim must be provided by a healthcare facility/physician to the insurance carrier, the employer, the employee, their attorneys, or the applicable State Workers' Compensation Commission pursuant to the NV Code NRS616C.050. I/We authorize Touro University Nevada Patient Clinic to provide copies of my medical records or to speak to duly authorized representatives of any of the above regarding my medical records, medical treatment, or condition.

CONTROLLED SUBSTANCE PRESCRPTIONS

Touro University Nevada Patient Clinic reserves the right not to prescribe narcotic medications. If you take narcotic medications for pain control on a regular basis, you must see a pain management physician. No narcotic prescriptions will be given for new patients on the initial visit until a complete work up has been performed and old records have been received. Controlled substance medications (narcotics, anti-anxiety, sleeping mediations, etc.) are very useful, but have high potential for misuse and abuse. These drugs are closely controlled by local, state, and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If you are prescribed such medications to help manage pain, you are responsible for the controlled substance medication. If the prescription is lost, misplaced, stolen, or use up medication sooner than prescribed, it will not be replaced. You cannot request nor accept substance medication from any other physician or individual while you are receiving this medication from your doctor. Prescription Refills of controlled substance cannot be called in to the pharmacy. They must be hand written and you must attend your scheduled appointment. You will be informed by your doctor about any side effects, including normal psychological effects of tolerance and dependence.

INFORMATION RELEASE

Other Person(s) authorized to discuss any medical information (including appointments, billing and insurance):

Full Name	Phone Number	Relationship

CONFIDENTIAL COMMUNICATION

You may request to receive confidential communications of Protected Health Information (PHI), i.e. Lab results, x-ray results, referral/prior authorization, prescription refills, in the method you prefer. ***Please select all that apply***.

I authorize Touro University health center to leave PHI messages at the following:

☐ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN A CALL
☐ Home Voicemail ( ) _____
☐ Cell Voicemail ( ) _____
☐ Work Voicemail ( )_____
☐ Patient Portal Web Message (email address required) _____

MEDICAL STUDENTS

You have the opportunity to assist future healthcare professionals by allowing them to participate with your physician in your appointment(s). **Please indicate below your preference to participate.**

☐ I will allow a medical student to participate in my appointment(s)
☐ I will not allow a medical student to participate in my appointment(s)

_____ *Initial*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I/We have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time.

Signature of Patient, Parent, Guardian or Legal Representative	Print name of Patient, Parent, Guardian or Legal Representative / Relationship to patient	Date
Signature of Witness	**Please print name of Witness / Relationship to Patient**	**Date**