PennState Health

Date of Birth: _____

MRN#: _____

CONSENT TO TREATMENT AND PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned is under the care of his/her attending physician(s) and hereby consents to and authorizes Penn State Health to provide the necessary medical treatments (including Emergency Department services), surgical procedures, anesthesia, x-ray examinations or treatments, laboratory procedures, telemedicine services, drugs and supplies to the patient as ordered or requested by the Professional Clinical Staff of Penn State Health. I acknowledge that no guarantee or assurance has been made as to the results of medical treatments, surgeries, or examinations. For the purpose of advanced medical knowledge, I consent to the presence of medical students and other health care trainees. I understand they may participate in my care under the direct supervision of my attending physician(s).

CONSENT TO ACCESS, REVIEW AND RETAIN PREVIOUS PRESCRIPTION MEDICATION INFORMATION: I consent to and authorize Penn State Health healthcare providers to access and review any of my electronic prescription medication history information which may be available through the Surescripts Database, including but not limited to, prescriptions ordered and/or filled for me at any pharmacy which participates in the Surescripts Database. I understand that this historical prescription information will then become a permanent part of my electronic medical record at Penn State Health.

PATIENT'S RIGHTS AND RESPONSIBILITIES: I acknowledge that Penn State Health has provided me with written information on my rights and responsibilities as a patient. I am aware that a Patient Representative is available to me if I have additional questions or otherwise wish to speak with one.

MEDICAL RECORD RELEASE AUTHORIZATION: I acknowledge that Penn State Health's Privacy Notice has been made available to me. I understand that Penn State Health may disclose information about me and the treatment I am receiving, for purposes of continuous treatment, payment, and health care operations.

ASSIGNMENT OF BENEFITS: I assign and authorize payment directly to Penn State Health. I authorize any holder of medical or other information about me to release to my insurance carrier and its agents and/or to any entity with which Penn State Health contracts to provide clinical services to its patients, any information needed to determine these benefits, or benefits for related services.

INDIVIDUAL FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for my health insurance deductible, coinsurance, and co-payments which are payable at the time of service. If my health insurance requires a referral, I must obtain the referral and present it at the time of my visit. In the event my health insurance determines a service to be "not payable," I will be responsible to pay for the charge(s) for all services provided. If I do not have health insurance or my health insurance cannot be verified, I agree to pay for the medical services rendered to me at time of service.

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I, the undersigned, certify that I have read, understand, and agree to the provisions contained within this consent form. The issues addressed on this form have been fully explained to me. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

_____ _____

Patient's Signature (or signature of person consenting on behalf of the patient) Date/Time

_____

Printed Name of person signing above

_____

Relationship to the patient, if applicable

_____ _____

Witness to Patient's Signature Date/Time

PennState Health
Medical Group

Date of Birth: _____

MRN#: _____

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____

From time to time it may be necessary for representatives of **Penn State Health Medical Group** to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Prescription renewal/reminder information
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share other information about your Protected Health Information.

I authorize Penn State Health Medical Group providers and/or staff to contact me and leave messages that could include Protected Health Information pertaining to my care by the methods selected below. I authorize Penn State Health Medical Group to leave detailed, personal health information by the following means:

Check and complete all that apply:

	Method	Number w/ Area Code
☐	Home telephone/voice message	
☐	Cell Phone/voice message	
☐	Work telephone/voice message	
☐	Other_____	
☐	*Email ***PATIENT PORTAL ONLY***	Email address:

*If I have authorized contact via email, I understand that the message may not be encrypted and therefore security from unauthorized access cannot be guaranteed. I further understand that Penn State Health Medical Group cannot guarantee receipt of a message.

AUTHORIZATION TO SHARE PERSONAL HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	Relationship	Number w/ Area Code

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Penn State Health Medical Group in writing should I wish to change any information noted above and to notify Penn State Health Medical Group if my contact information changes.

Patient or Legally Authorized Representative's Signature Date