General Consent for Treatment, Assignment of Benefits, Patient Responsibility for Payment

MARTIN'S POINT® HEALTHCARE

Patient Name: _____ **Medical Record #:** _____

Date of Birth: _____

I, the undersigned, being either the patient or the patient's legally authorized representative, do hereby:

GENERAL CONSENT FOR TREATMENT

- Consent to routine medical treatment and/or evaluation, including but not limited to laboratory and X-ray examinations
- Understand that separate consents will be requested for certain special procedures

ASSIGNMENT OF BENEFITS

- Assign all benefits under any insurance or health benefit plan for payment for medical services rendered by a Martin's Point provider to Martin's Point Health Care and further agree to remit payment to Martin's Point Health Care within thirty (30) days of any benefits paid directly to me

PATIENT RESPONSIBILITY FOR PAYMENT

- Accept financial responsibility for any amount not paid by insurance or other health benefit plans

REQUIRED FORMS

I have received a copy of the Martin's Point Health Care "Patient Rights and Responsibilities" and a copy of the Martin's Point Health Care "Notice of Privacy Practices." I understand that it is my responsibility to read this information, and ask any questions that I may have. I further understand that current copies of both documents will be maintained in the Patient Education area at all times for my review and are also available upon request.

I understand this document remains in effect for as long as I continue to visit Martin's Point Health Care, unless specifically rescinded in writing.

Patient 18 years of age or older:

Patient	OR	**Legal Representative**
Signature: _____		Signature: _____
Print Name: _____		Print Name: _____
Date: _____		Date: _____

Patient under 18 years of age:

Parent, Guardian, or Legal Representative

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

Note: *POA (copy of legal document(s) required for placement in patient medical record)*