

## Consent to Treatment / Health Care Agreement

**CONSENT TO TREATMENT:** I voluntarily consent to receive medical and health care services provided by TTUHSC physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital, and/or other images may be recorded for treatment purposes. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the TTUHSC Ambulatory Clinics unless revoked by me in writing with such written notice provided to each clinic attended by me.

**RELEASE OF MEDICAL INFORMATION:** Your protected health information pertains to your diagnosis and/or treatment at TTUHSC, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

Our Notice of Privacy Practices provides information about how TTUHSC and its workforce may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to TTUHSC physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

**I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by TTUHSC.**

I certify that I have read this form or it has been read to me\*

**ADVANCE DIRECTIVE:**

Has an Advance Directive been signed?  YES  NO

If yes, is it still in effect?  YES  NO

Has a signed copy been provided to TTUHSC?  YES  NO

**NOTICE OF PRIVACY PRACTICES:**

I have received a paper copy of TTUHSC's Notice of Privacy Practices. \_\_\_\_\_  
(Patient's Initials)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Patient/Other legally authorized person

\_\_\_\_\_  
Witness\*

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print name and relationship to patient

