Samaritan
Family Health Center
Watertown, NY

PATIENT CONSENT RECORD

Patient Name: _____ Date of Birth: _____

**Patient identifiers utilized to confirm above.

Consent for Treatment

I hereby authorize the Samaritan Family Health Network and its representatives to conduct any diagnostic, routine, or emergency examination, tests, and procedures, to obtain specimens from myself, or a minor child if signed by a Representative, and to provide any medications, treatment or therapy as it is now deemed or as it may be deemed on subsequent visits. I understand that it is the responsibility of my provider to explain to me the reasons for any examination, test, or procedure, the available treatment options, alternative courses of treatment, the common risks and the anticipated benefits, and the risks associated with declining care.

☐ **YES**, I give my consent to treatment. ☐ **NO**, I do not give my consent to treatment.

Permission to Disclose to Family/Other Individuals

You may authorize the Samaritan Family Health Network and its representatives to disclose your protected health information to family members or other individuals in order to assist with your continuing care.

☐ **YES**, I give permission to disclose my protected health information to the following family members and individuals:

Date of Permission	Name of Individual	Relationship

☐ **NO**, I do not give permission to disclose my protected health information to family or other individual.

Have you completed any of the following Advance Directives?

Please check all that apply. If checked, please provide us with a copy.

☐ I have a **LIVING WILL**
☐ I have a **NON-HOSPITAL DNR**
☐ I have a **POWER OF ATTORNEY**
☐ I have a **HEALTH CARE PROXY**
☐ I have a **MOLST** form

Name of Health Care Proxy:_____ Phone Number:_____

Acknowledgment of Understanding

☐ **YES**, I have received a copy of the **Patients' Bill of Rights**, and information relative to **Advance Directives** including **New York State Health Care Proxy** information. I have had an opportunity to ask any questions I may have pertaining to these materials.

Authorization to Process Claims and Release Information

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☐ **YES**, I authorize Samaritan Family Health Network and its representative to release any information they obtain, including medical information, to my Insurance Company or to their representatives, to process claims for payment.

Guarantee of Payment and Authorization of Benefits

☐ **YES,** I agree to assign and transfer to the Samaritan Family Health Network all benefits and payments due and payable or to become due and payable to me under any insurance policy, self-insurance program, third-party action, or any other benefit plan program for as long as I receive services from the Samaritan Family Health Network.

☐ **YES**, I understand that this assignment does not relieve me of my financial responsibility for all charges incurred. I also accept financial responsibility for charges not directly reimbursed to the Samaritan Family Health Network. Furthermore, I agree to pay all costs incurred for collection and reinforcement of this payment obligation.

My signature confirms I have been given an opportunity to review this form for accurateness, ask questions, and all of my questions have been answered fully and satisfactorily.

_____ _____
Signature Date

_____
Relationship to Patient

I attest that the patient has no further questions and has electronically signed this form.

_____ _____
Witness (name/title) Date