GENERAL CONSENT FOR MEDICAL TREATMENT

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative hereby voluntarily consents and authorizes such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications by employees and authorized agents of Santa Maria Health including all affiliated physicians, physician assistants, nursing staff and other ancillary providers as may be considered necessary or advisable in their professional judgment. I, the undersigned, am aware that the practice of medicine is not an
exact science and further acknowledge that no guarantees have been made regarding the effect such treatments may have on any medical condition.

RIGHT TO REFUSE TREATMENT: The undersigned responsible party further understands that he/she has the right to make informed decisions regarding all care and treatments, and that he/she may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments.

RELEASE OF INFORMATION: I hereby authorize Santa Maria Health to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third-party payers including employers, health service plans or worker's compensation carriers.

I acknowledge having received the Notice of Privacy Practices which outlines which health information may be used or disclosed.

I consent to such disclosures as delineated in the Notice and understand that this may include information related to behavioral health services and treatment for alcohol and/or drug abuse.

ASSIGNMENT OF HEALTH BENEFITS: I, hereby authorize and instruct the insurance carrier to make payment directly to Santa Maria Health for any medical benefits otherwise payable to me or my guarantor as payment toward the total charges for professional services rendered. I understand that insurance co-payments, co-insurance and non-covered services are my or my guarantor's financial responsibility.

FINANCIAL AGREEMENT: I, the undersigned, agree to pay, whether signing as a patient or representative of the patient, the charges incurred at Santa Maria Health in keeping with the established fee schedule. I understand that if I am a member of a Health Maintenance Organization (HMO) and have not secured authorization for payment of services, I will be held financially responsible for all non-covered services. I also understand that I am responsible for any balance owed and that a cash deposit will be required for patients not otherwise approved for the sliding fee discount program or other
public benefits.

ADVANCE DIRECTIVES: Adults 18 and older have the right (a) to give direction about their future medical care or (b) to designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I, the undersigned, understand that information about advance directives is available to me upon request.
I have executed an Advance Directive YES NO (If yes please provide us with a copy)
I would like further information. YES___ NO ___

Patient Name: Parent/Legal Representative Name: _____

Patient/Legal Representative Signature: _____ Date: _____

Witness Name: _____Date: _____