Washington University Physicians®
Washington University School of Medicine in St. Louis

Patient name:_____

DOB: _____

AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by the Washington University School of Medicine and its wholly owned subsidiaries (hereinafter referred to as "WU"), its house staff, employees, and students to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results. I further authorize my physician to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any bones, organs, tissue, fluids or parts removed from my body.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician, WU to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring
c. Any continuing care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE/TRICARE INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by WU. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accepts the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

Patient name:_____

DOB:_____

4. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by WU, the undersigned agrees, whether he/she signs as patient or guarantor, to pay WU, physicians for all services ordered by the attending physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

5. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by WU, all attending physicians, I authorize direct payment to WU of all insurance benefits applicable to these medical services, which are now or which shall become due and payable to me.

6. HIPAA – NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that WU, the physicians, the nurses and other University staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern WU operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient _____

Signature of patient or person authorized to consent	Date	Patient's relationship to person
Signature of guarantor	Date	Patient's relationship to guarantor
Signature of witness	Date	