

# General Consent for Treatment and Receipt of Notices

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Authorization for Treatment:** I do hereby acknowledge, agree, and give my consent for medical, behavioral health, chiropractic, and dental diagnosis and treatment as deemed necessary by Noble Community Clinics (Noble) as indicated appropriate by my treating provider, their assistants and/or designees. This authorization includes, but is not limited to, routine procedures, outpatient services, laboratory tests, x-rays and other tests or procedures. I understand the general nature of the services available and have discussed, or will discuss, the individualized Plan of Treatment and reasonable alternative treatment modalities with my provider. I will discuss potential benefits, risks, side effects, and possible outcomes of the treatments recommended in my Treatment Plan. I understand the recommendations and anticipated benefits of treatment, the approximate duration of treatment, and the desired outcomes as explained by my provider, including the risks and outcomes of not engaging in, postponing, or discontinuing recommended treatment. I understand that my physician/practitioner(s) or other health care providers may be accompanied and/or assisted by students, interns, and or residents during my care. I consent to the presence and/or participation in my treatment by these persons at the discretion of or while under the supervision of my physician/practitioner(s) or other authorized health care providers. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result of examination and treatment received at this facility. I acknowledge that my care is under the direction of my treating provider and Noble will follow the instructions of my provider(s) in the position in said care.

**Patient Care:** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well-being.

**Personal Valuables:** I accept full responsibility for all property in my possession. I understand that Noble maintains no responsibility for property that is personal and in my possession.

**Assignment of Benefits, Authorization to Release Information to Insurance Company & Statement of Responsibility:** I hereby assign all insurance benefits including Medicare/Medicaid to Noble and authorize direct payment to facility. This payment includes all payments for charges incurred for any services provided to me by Noble. I give permission to Noble to release any medical information about me to my insurer including Medicare/Medicaid and its agents for the purpose of deciding benefits and processing claims. I agree to be responsible for charges not covered by insurance. I understand that I am financially responsible to Noble as the patient, guardian, conservator, and/or insured for all charges not covered by the above assignments or programs. Charges may include insurance deductibles, co-insurance, and/or out-of-pocket expenses. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicaid and any self-pay and /or sliding fee details. If a responsible party is designated, that party acknowledges financial responsibility consistent with this section.

**Authorized Representative:** I hereby authorize Noble to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by Noble.

**Non-covered Medicare/Medicaid Services:** The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical record indicates any of the listed treatments or care.

**Advanced Instructions for Healthcare:** I understand that I may provide written Advanced Directives – such as a Living Will executed under Wis. Stat. ch. 154 or a Power of Attorney for Health Care executed under Wis. Stat. ch. 155 – to indicate my preferences for medical treatment or non-treatment if I become unable to communicate. Wisconsin law recognizes these documents as valid when properly completed and signed. Noble will honor valid advanced directives in accordance with Wisconsin statutes and the facility policy. To ensure these directives can be followed, I agree to provide copies of my completed documents so they may be filed in my medical record.

**Personal Representatives:** Please list your personal representatives (18 years of age or older<sup>1</sup>) authorized to access your protected health information (PHI) and/or consent to treatment on your behalf.

Under Wisconsin law, guardians and health care power-of-attorney (HC-POA) cannot delegate their authority to provide medical consent. A court-appointed guardian is legally responsible for making decisions on behalf of their ward. A guardian may not delegate this decision-making authority to another individual unless such delegation is specifically authorized by the court. Therefore, all consent forms for medical care, treatment, or services must be signed directly by the guardian. If the guardian is unavailable to appear or sign, consent cannot be provided by another person in their place and therefore, services may be rescheduled. If the guardian is unable to appear in person to sign the consent form, Noble may obtain verbal consent directly from the guardian by phone.

Name	Relationship	Address	Phone Number	Consent to Treatment <small>*POA, Temporary/Permanent Guardian may not delegate consent</small>	Consent to exchange verbal PHI <small>*Written records requires ROI</small>
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Telehealth Consent:** I understand that some of my care may be provided through telehealth using secure video and/or audio. Telehealth is optional, and I may request in-person care at any time; however, I understand that for certain services or provider availability, telehealth may be the only option offered. Telehealth services are billed similarly to in-person visits, and normal copays or cost-sharing may apply based on insurance. Your information will be protected under HIPAA and any other applicable state or federal regulations.

**Consent for OCHIN:** Noble Community Clinics (Noble) is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at [www.ochin.org](http://www.ochin.org). As a business associate of Noble, OCHIN supplies information technology and related services Noble Community Clinics (Noble) and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Noble with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement. Health care operations can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

**HIPAA Privacy Notice:** I acknowledge that I have been offered or received a copy of Noble Community Clinics (Noble) Notice of Privacy Practices and Patient’s Bill of Rights and Responsibilities.

I give my consent to Noble Community Clinics to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as deemed necessary: (Check all that apply)

- On answering machine or voicemail on home phone or cell phone
- On answering machine or voicemail on work phone
- I do not consent to messages being left at home, work, or with another person. I wish to be contacted directly.

\_\_\_\_\_  
Patient Signature/Parent if Minor/Power of Attorney/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Insurance Policy Holder (if not the same as above)

\_\_\_\_\_  
Date

<sup>1</sup> Emancipated minors are excluded from the age restrictions.