APS GENERAL CONSENT and AUTHORIZATION FOR TREATMENT

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of WMCHealth Advanced Physician Services, PC (APS), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood. I understand and authorize the administration of pharmaceutical agents and medications. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at APS.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct APS and my attending physician 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 payors.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND FINANCIAL ASSISTANCE PROGRAM: I hereby assign to APS any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by APS, whether such services are considered in-or out-of-network with respect to any third party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to APS, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to APS for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. If treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules. As part of APS's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. WMC has a Financial Assistance Program for patients who financially qualify. Please ask for more details.

CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND EMAILS: I hereby consent to APS or a business associate (s) of APS to contact me by voice call, postal mail, text message and/or email at the Account contact homes address, telephone number (s), and Email address (es) reflected on my account. I understand that, by giving this consent, APS may contact me about my medical care or my account, such as but not limited to, appointment, the results of any tests or procedures, business operations, quality reporting, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

WMC Health | WMCHealth **Physicians**
Advanced Physician Services
Westchester Medical Center Health Network

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed by APS, and how I may obtain access to and control this information. I acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE: By signing below, I acknowledge receipt of the important information about paying for your care.

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the private practice and agree that APS shall not be liable for loss or damage to any personal property.

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____
Patient

Signed: _____
Legal authorized Representative

Witness: _____

Date: _____Time: _____

TELEPHONE CONSENT IF GRANTED BY (if required)

Signed: _____
Name of legal representative and relationship to patient.

Signed: _____
Signature of caller.

Witness: _____

Date: _____Time: _____

Patient Signature: _____ Date: _____ Time: _____