Patient Consent Form

Rettig Family Health Care
A Limestone Medical Center Clinic

Authorization for Care: I grant permission to the employees of Rettig Family Health Care, a Limestone Medical Center clinic, to examine, treat, and perform diagnostic tests and procedures that my provider deems necessary.

Authorization of Care by PA: I understand that my care may be provided by a Physician Assistant in consultation with a physician. There may or may not be a doctor of medicine or osteopathy present in the clinic 24 hours per day, seven days a week. My signature on this form constitutes my consent to treatment by this professional.

Assignment of Benefit: Insurance Assignment: In consideration of services rendered, I hereby assign and transfer to Rettig Family Health Care, a Limestone Medical Center clinic, any benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered.

Financial Agreement & Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Rettig Family Health Care, a Limestone Medical Center clinic, may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this assignment and / or not paid by said companies and payers.

Medicare Lifetime Authorization: By signing below, I authorize any holder of medical or other information about me to release to the Social Security Administrations and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any medical costs not covered by Medicare.

Non-Smoking Facility: I understand this is a non-smoking facility and I will abide by this policy.

Valuables: I understand that Rettig Family Health Care, a Limestone Medical Center clinic, is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of and not replaced by Rettig Family Health Care, a Limestone Medical Center clinic.

HIV, HBV, and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1) if donation of blood, blood products, organs, or tissues is contaminated; (2) if a healthcare worker is accidentally exposed to a patient's blood or bodily fluids; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure informs that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV & HCV testing under any of the above situations.

Privacy Practices: Rettig Family Health Care, a Limestone Medical Center clinic, is required by law to maintain the privacy of a patient's protected health information (PHI). In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to PHI.

Patient Rights and Responsibilities: I have been given the opportunity to review my rights and responsibilities as a patient. I understand my rights because they have been explained to me and my questions have been answered.

Authorization to Release Information: By signing below, I authorize Rettig Family Health Care, a Limestone Medical Center clinic, to release information requested by insurance companies, review agencies or other third-party payers for payment of claims arising out of this visit. **I give permission, without limitation or exclusion, for Rettig Family Health Care, a Limestone Medical Center clinic, and its providers to view my external prescription history for purposes of my care and treatment.** I understand that my medication history from multiple other medical providers, insurance companies, and pharmacy benefit managers may be viewable and that granting this permission will allow my providers to better coordinate my care and to maximize the effectiveness and safety of my treatment plan.

_____ _____

Signature of Patient or Patient's Representative Date & Time

_____ _____

Witness Signature Date & Time