PATIENT CONSENT TO TREATMENT AND ACEPTANCE OF FINANCIAL RESPONSIBILITY

1. General Consent to Treatment.

I hereby consent to and authorize "Saco River Medical Group", its providers, residents, interns, employees, students, and other individuals involved in my care to conduct examinations diagnostic tests, and procedures to effectively diagnose and and treat me. I understand that it is the responsibility of my treating healthcare provider (s) to explain to me the purpose of the proposed care, treatment, services, prescribed medication, suggested interventions, or procedures. Before I undergo procedures or tests, my treating healthcare provider (s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of choosing not to undergo treatment.

Right to Refuse Treatment. I further understand that I have the right to refuse any suggested examinations, tests, procedures, treatments, therapies, or medications recommended to me by my treating healthcare provider (s).

Minors/Incapacitated Adults: As a legal guardian/legally authorized representative, I understand that I am giving the same consent to the healthcare provider (s) at this medical practice for the treatment of the child or person whom I am the legally authorized representative.

2. Authorizations to Receive Payment.

I hereby authorize Saco River Medical Group to directly receive payment of benefits from an insurer managed care organizations, workers' compensation, governmental agency (for example, Medicare, Medicaid, Wellsense, NH Healthy Families, Tricare), or other third party that is responsible for payment of the healthcare services provided to me. I understand that I am responsible for some or all of the cost of my healthcare services even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. These costs may include deductibles and co-payments not covered by my health insurance. In the event that any healthcare services are denied by workers' compensations, I understand that I am responsible for payment and authorize Saco River Medical Goup to receive payment from my private health insurance.

I understand that I may choose to pay privately in full for the particular services if I do not wish certain sensitive health information to be disclosed to my health insurance.

I agree that patient named on this form (myself or another over whom I have legal authority) is covered by the health insurance information that I have provided and that I have not received a noticed of discontinuation of benefits.

3. For Minors

If you are a minor who consents to healthcare services on your own behalf but utilized your parent's or guardian's health insurance to pay for your services, please know that your parents or guardian will receive an explanation of benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for these services in another manner.

4. Non-Discrimination Policy

Saco River Medical Group does not discriminate on basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation.

By signing below, I acknowledge that I have read the above information and that:

I have been offered a copy of the Patient financial Policy Notice
I understand and agree with the above statements
I have been given the opportunity to have my questions about this form answered.
I understand that this document remains in effect while I continue to receive care at this office or any other Saco River Medical office or provider and for a maximum of 12 months from the date of this form.

Signed:_____Date:_____

Print name:_____

If signing for child:
Childs name:_____DOB:_____