## FINANCIAL/CONSENT for TREATEMENT

**Financial Policy/Authorization for Medical Care and Billing:**

Non-covered medical services are the responsibility of the patient, or in the case of a minor, the responsibility of the minor's parents or legally appointed guardian. I understand I am financially responsible for medical services regardless of any divorce decree or court order. This includes services rendered to minors who may be covered by another parent's insurance under a custody agreement. I understand that my insurance policy is a contract between myself and the insurance company, claims submission by Triad Health Systems, Inc. (THS) is performed as a courtesy and THS will not become involved in disputes with my insurance carrier.

I authorize the release of any medical information necessary, to process my claims. I do hereby consent to such medical, dental, and/or surgical examination and treatment (face-to-face or phone/telehealth services) as is necessary and authorize the provider to release to Third Party Sources information necessary to obtain payment for services rendered.

**I also consent to authorize the provider to release any referring doctor information necessary for evaluation and treatment.**

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PATIENT CONSENT FOR TREATMENT:

I ***voluntarily authorize the rendering of such care***, including diagnostic tests, procedures and medical treatment (either face-to-face or phone/telehealth) by authorized agents and employees of Triad Health Systems, Inc. (THS), and its medical staff, or designees as may, in their professional judgment, be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such treatments of procedures on my condition. I understand that I have the right to make decisions about my health care or the health care of the person for whom I am legally responsible, including the right to refuse medical and/or surgical procedures: (check one below that applies)

_____I have formulated an Advance Directive (living will, health care surrogate, declaration, durable power of attorney) and request that these directives govern my care according to Kentucky state and/or federal laws. I understand that it is my responsibility to provide THS with a copy of my duly executed Advance Directive and that those directives will not govern my care until they have been filed in my medical record.

_____Advance Directive attached.

_____Advance Directive not attached.

_____I have not formulated an Advance Directive, but I understand that is my right to make decisions regarding my course of treatment, including the execution of an Advance Directive.

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## Authorization of CONSENT

**I have read and understand what I am signing for below and by signing this form, I give my consent for**

(patient's name) _____ to receive services (which may include one or all of the following: medical/behavioral health/optometry/dental/phone or audio/telehealth) at Triad Health System's Inc. (THS) Clinics.

THS cannot/will not provide services to the patient without this signed consent (except for an emergency situation).

**Right to Terminate or Revoke Authorization:** The consent can be withdrawn/revoked at any time by the patient (if 18 yrs. old or older), parent or legal guardian submitting a signed, written revocation to the THS office.

**Patient/Parent or Legal Guardian SIGNATURE: _____DATE: _____**