



General Consent For Treatment & Acknowledgement – Initial each section

_____ **Medical consent:** I consent to receive medical care, treatment, tests, imaging, and procedures as deemed necessary by the providers at **Rheumatology Partners of Houston, LLC (RPH)**, including physicians, physician assistants, and their clinical staff. This includes the use of medications, blood products, pathology, radiology, and other services recommended for my care. I understand that no guarantees have been made regarding treatment outcomes. I also authorize the examination, use, storage, or proper disposal of any tissue or fluid removed during my care. In the event of accidental exposure of my blood or bodily fluids to healthcare personnel, and if I am unable to provide timely consent, I authorize limited testing for hepatitis A, B, C, and HIV to protect those involved in my care.

_____ **Right to refuse treatment:** I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatment that I do not want.

_____ **Acknowledgement of receipt of patient rights & notice of privacy practices:** I acknowledge both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices are available to be either in the office,

_____ **Release of medical information:** I authorize **RPH** to release any information necessary to facilitate healthcare processing of claims, and audit of payments related to my care/treatment from **RPH**. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

_____ **Assignment of insurance benefits:** I hereby assign all applicable medical and major medical benefits to which I am entitled to **RPH**. I authorize and direct my insurance carrier(s) - including Medicare, Medigap, Medicare Advantage, private insurance, and any other health or medical benefit plan to issue payment directly to **RPH** for services provided to me. I understand that I am financially responsible for any charges not covered by my insurance.

_____ **Medicare certification:** I certify that the information I have provided for Medicare payment is accurate. I authorize the release of medical or other relevant information to the Social Security Administration and its agents as needed to process this or related Medicare claims. I request that authorized benefits be paid on my behalf. *(Applies only if Medicare coverage is in effect.)*

_____ **Consent to obtain external prescription history:** I hereby authorize **RPH** and its providers to access my external prescription history through our charting software. I understand that this may include prescription information provided by other healthcare providers, insurance companies, and pharmacy benefit managers not affiliated with **RPH**. I acknowledge that this history may include medications prescribed over the past several years and may be reviewed by my providers and their authorized staff for the purpose of providing safe and effective care.



RHEUMATOLOGY PARTNERS OF
HOUSTON, LLC

129 Vision Park Blvd., Ste. 206, Shenandoah, TX 77384
4747 Bellaire Blvd., Ste. 150, Bellaire, TX 77401
O: 281-315-8130 F: 281-315-8131 & 281-315-8132

General Consent For Treatment & Acknowledgement *continued*

_____ **Financial agreement:** I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists. I understand I am financially responsible to **RPH** for charges not paid under this agreement. I am responsible for all charges for services which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. **RPH** will make every attempt to notify me in advance if a service is not covered. I am responsible for and agree to pay all co-pays, deductibles, and patient responsibility balance(s) at the time of service unless other arrangements have been made in advance.

_____ **Insurances requiring referrals:** I am presenting my insurance information for my appointment with Dr. _____ at **RPH**. I understand that it is my responsibility to ensure that a valid referral, if one is required, has been submitted to my insurance company by my current primary care provider for my visit today. ** If a referral has not been obtained, I will be responsible for all charges incurred at today's visit, including lab and x-ray if applicable. **

Receipt of Notice of Privacy Practices

_____ I acknowledge that I have received a copy of the **HIPAA Notice of Privacy Practice**, which describes how my health information may be used and disclosed, and how I can access this information. I understand that the Notice of Privacy Practices may be amended as allowed by law, and that a current copy will always be available upon request and on the practice's website at www.RPHdocs.com.

Patient Name (print): _____ Today's Date: _____

Patient Signature: _____