Alabama Regional Medical Services

CONSENT

I hereby authorize the physicians, nurses, and other healthcare providers of Alabama Regional Medical Services (ARMS) to provide such medical assessment and treatment, including drugs, medications, diagnostic and therapeutic procedures, tests, or treatment (including HIV and Hepatitis C) as may be ordered and performed by ARMS.

Initial only if declining: I Decline HIV Testing: _____ I Decline Hepatitis C Testing: _____

SECURITY AND SAFETY

I hereby authorize the use of video surveillance cameras for the purpose of ensuring the safety and security of patients and staff. I understand that images may be recorded for review. I give ARMS the absolute and irrevocable right and permission to use video tape devices to monitor the facilities. **Initial:_____**

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize ARMS to furnish any medical information requested by insurance companies or public agency, i.e. Medicare or Medicaid, with which I have coverage, any public agency, i.e. Medicare or Medicaid, if it is assisting in payment of my care. I authorize my information to be given to another physician for continuation of care purposes. **Initial:** _____

ASSIGNMENT OF BENEFITS

I hereby assign to ARMS, or duly authorized agents and/or assigns, all rights benefits and interest in all proceeds from Third Party Payers. I authorize payment directly to ARMS of benefits otherwise payable to me for services rendered and further authorize ARMS to take all necessary actions to ensure that any such benefits are paid directly to ARMS. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid to ARMS in excess of regular charges will be refunded as appropriate. **Initial**: _____

FINANCIAL RESPONSIBILITY

I acknowledge that I am legally responsible to ARMS for, and I agree to pay to ARMS, for all charges whether or not covered by my insurance carrier or any other entity or program. If the responsible party is someone other than me, I hereby consent to Alabama Regional Medical Services disclosing to the responsible party my personal health information.
Initial: _____

ACKNOWLEDGEMENT OF PATIENT'S RIGHTS AND RESPONSIBILITIES PRIVACY POLICY

I acknowledge that I have received a copy of the Patient's Rights and Responsibilities. I also understand that to help protect the privacy of my identifiable health information, Alabama Regional Medical Services (ARMS) has established a *Privacy Policy* and guidelines for privacy practices within their offices. This information details the use and/or disclosure of information contained in my personal health records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the *ARMS Privacy Policy* has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.
Initial: _____

_____ Date:_____
(Signature of Patient or Legal Guardian)

_____ Date:_____
(Witness Signature)