

THE ZUCKER HILLSIDE HOSPITAL, A DIVISION OF NORTHWELL HEALTH
P.O. Box 38, Glen Oaks, NY 11004

Patient Name: Last _____ First _____ Middle _____

Authorized Representative: _____ Relationship: _____

General Consent for Treatment

I hereby consent to and authorize the physicians and/or their designees of Zucker Hillside Hospital Faculty Practice (hereinafter, the "Practitioners") to evaluate my medical condition and conduct any routine and non-invasive diagnostic and therapeutic procedures and treatments (excluding all invasive procedures and procedures that bear risk to life or health), which in the Practitioners' judgment are necessary for my care. I understand that I have a right to refuse or recommended treatment once it has been explained to me.

Date _____ Signature of Patient or Authorized Representative _____

Consent for Release of Information to Insurance Companies and Third Party Payers

I hereby authorize and direct the Practitioners, having treated me, to release to governmental agencies, insurance carriers and/or others who are financially liable for my medical care, all information needed to substantiate payment for such care and to permit representatives thereof to examine and make copies of all records relating to such treatment to the extent necessary to process claims.

Date _____ Signature of Patient or Authorized Representative _____

Assignment of Benefits to the Practitioners

I hereby assign, transfer, and set over to the Practitioners sufficient monies and benefits to which I may be entitled from governmental agencies, insurance carrier, and/or others who are financially liable for my medical care to cover the costs of the care rendered to me or my dependent by the Practitioners.

Date _____ Signature of Patient or Authorized Representative _____

Patients Entitled to Medicare Benefits

I certify that the information given by me in applying for payment under the XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carries any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made either to me or on my behalf to the Practitioners. I assign the benefits payable for physician services to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment for such services.

Date _____ Signature of Patient or Authorized Representative _____

Financial Responsibility / Guarantee of Payment

For, and in consideration of, services rendered or to be rendered by Practitioners, I hereby guarantee payment of any bills for such services that are not covered or allowed by the governmental agencies or insurance carriers financially liable for such services.

Signature of Patient or Authorized Representative _____

Drug/Alcohol Treatment Records

I authorize Practitioners to disclose to _____ (name of person or organization to which disclosure will be made) the following information for the following purpose(s): ☐ Attendance / ☐ Treatment Plan(s) / ☐ Evaluations / ☐ Lab Test Results / ☐ Medical Records / ☐ Diagnosis (es) / ☐ Treatment Summary / ☐ Other: _____

Specific purpose(s) of disclosure: _____

In the event this authorization is utilized for payment purposes, unless otherwise indicated, I further permit the Practitioners to release any information necessary to facilitate such payment even if these items are not checked above.

I have been fully advised of the nature of the information requested prior to my signing this form. I understand that there are special federal confidentiality regulations that protect these records (42 CFR Part 2). I further understand that these regulations provide that the records cannot be disclosed or re-disclosed by the recipient without my specific written permission, except under limited exceptions stated in the regulations.

I understand that I may revoke this authorization at any time. However, I also understand that at the time I withdraw my authorization, action such as releasing information may have already occurred because I signed this form, and this is acceptable to me. Unless otherwise indicated, this authorization is valid for _____ (specify period of time, i.e., 180 days, 1 year, etc.) or in the event this authorization is utilized for payment purposes, until such time as payment has been completed.

Date _____ Signature of Patient _____

Date _____ Signature of Patient _____

THIS DOCUMENT IS TO BE FILED UNDER "DEMOGRAPHIC DATA / CONSENT"