OUTPATIENT DIABETES EDUCATION CONSENT FORM

☐ **Consent for Medical Treatment**

The patient named below has been informed of the nature and purpose of his/her treatment and/or procedure, is aware of the risks involved and hereby voluntarily consents to the rendering of such treatment/procedure. The patient understands and acknowledges that no guarantee or assurance has been made as to the results that may be obtained from the treatment/procedure.

☐ **Consent for Medical Treatment**

I authorize the use of videoconferencing for my consultation over the Northwest TeleHealth network in lieu of a direct patient to physician contact. I understand that as with any electronic technology, there may be disruptions associated with the telemedicine network which are beyond the control of (a) NW TeleHealth Network, affiliates, agents and employees, and (b) my healthcare provider and his or her designee(s). Therefore, I release such parties from any liability in connection with the use of the TeleHealth Network.

☐ **Consent for Release of Information**

The patient named below consents to the release of information for medical treatment to the practitioners or medical organizations responsible for follow-up care (Listed below) and to insurance companies or third party payers. This release shall cover the following information unless otherwise noted: medical, psychological, drug and alcohol, AIDS, and sexually transmitted diseases. This consent will expire 90 days from the date shown below. I reserve the right to withdraw this authorization at any time subject to receipt of payment in full. I authorize the release of information to the following practitioner(s) at this time.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for **HIV (Aids virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or alcohol abuse,** and by signing below I specifically authorize to release all health care information related to such testing, diagnosis, and /or treatment of the above named conditions. The consent of the specific above-mentioned conditions will expire 60 days from the date signed below.

______________________________ ____________________

Patient Date

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Referring Physician Primary Care Physician Medical Organization

☐ **Consent to Treatment by Trainees**

The patient consents to other health care personnel in training being present during treatment and in some instances providing supervised treatment.

☐ **Promissory Note and Authorization to Pay**

I understand that I am financially responsible for all charges incurred as a result of the treatment I receive at this facility. In the event my account is not paid within 90 days from the day of discharge, I agree to pay finance charges at a rate of one percent (1 %) per month. Should any of my accounts be referred for collection, I agree to pay all court costs, reasonable attorney fees and collection expenses. The parties agree that if any action is taken to collect this account, the venue will be Spokane County.

☐ **Medicare Assignment**

PART A: Patient's certification, authorization to release information and payment request: I certify that the information given to me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information related to Medicare claims about me be released to the Social Security Administration or its intermediaries or carriers. I request payment of authorized benefits be made on my behalf.

PART B: I authorize any holder of medical or other information related to Medicare claims about me be released to the Social Security Administration or its intermediaries or carriers. I understand that I am responsible for any health insurance deductible and co-insurance.

I further acknowledge receiving a copy of the Patient Rights and Responsibilities.

Inland Northwest Health Services does not discriminate on the basis of age, sex, marital status, race, creed, color, national origin or the presence of any sensory, mental or physical disability.

______________________________________ ________________________

Patient Signature/Authorized Person/Guardian Date

______________________________________ ________________________

Witness Date Relationship to Patient

Addressograph/Label

INHS/Community Health Education & Resources
Spokane, WA.