Cedars Sinai

MEDICAL CARE FOUNDATION

CONDITIONS OF TREATMENT

PATIENT I.D.

1. **Patient consent for services**
   I hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of the Cedars Sinai Medical Network. These may include but are not limited to: emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, or anesthesia provided to me under the general and special instructions of my physician or surgeon.

2. **Financial responsibility for services**
   I hereby authorize my insurance benefits be paid directly to Cedars-Sinai Medical Care Foundation. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and will remit appropriate payment at the time of service, including specifically copayments and charges for services which are not covered by my insurance.

3. **Copayment policy**
   If applicable, at the time of check-in I will be required to pay a copayment. If I do not pay my copayment, I understand that my visit may be canceled.

4. **Insurance coverage**
   I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

5. **Referrals/authorization**
   I understand that, depending on my insurance, I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate or necessary. I understand that if I choose to access specialty services without prior authorization from my provider, or I elect to use a Point of Service option or fail to notify Cedars-Sinai Medical Care Foundation if my insurance plan requires specific outside vendors such as laboratories to perform referred services, I may be financially responsible for the services rendered and insurance may not cover the relevant services.

6. **Ancillary services**
   I understand that, depending on my insurance, I may receive a separate bill for laboratory, X-ray, anesthesia or other ancillary services.

7. **Release of information**
   I authorize the release of my medical records or other information necessary to provide healthcare, to process my medical claims, and for other purposes relating to the healthcare operations. I understand that Cedars-Sinai Medical Care Foundation is affiliated with Cedars-Sinai Health System, and as such, shares information with Cedars-Sinai Medical Center and its affiliate ancillary departments (e.g., laboratory and imaging). Additional information is provided in our Notice of Privacy Practices.

8. Fees for patient's health information

I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation if agreed to in advance.

9. Fee for forms

I understand, that if I request to have any forms completed by my physician that are not directly related to patient care I will be required to pay a fee. Examples of such forms include, but are not limited to, jury duty excuse, Family and Medical Leave Act application, accident reports, and school and camp forms. There may be other forms with associated fees.

10. On-time arrival policy

I understand that I must arrive at least 15 minutes before the time of my appointment in order to register and provide information prior to the time my physician is scheduled to see me. If I arrive late for my scheduled appointment, I understand that it may be necessary to reschedule my appointment. My physician attempts to maintain an "on-time" schedule, but I understand that urgent or complex needs for patients with prior appointments may cause my physician to be late for my appointment.

11. No-show policy

I understand that if I miss an appointment with less than 3 business hours' prior notice, I may be charged a fee for a missed visit.

12. Medication refills

I understand that refills may take 24-48 hours to complete and that the most efficient way to get a refill is to contact my pharmacy directly. In order to ensure timely medication refills, I agree to notify my physician's office regarding my preferred pharmacy.

13. Photography for patient identification

I understand that Cedars-Sinai Medical Care Foundation is deeply committed to my safety and identity protection. I agree to have my picture taken at check-in for inclusion in my medical record. I understand that my photograph will be used to protect me from identity theft, to ensure patient safety and to further personalize the services I will receive. My picture helps to confirm that all members of the Cedars-Sinai Medical Care Foundation care team are accessing the correct medical record.

14. Photography for clinical care

If clinically indicated, I will be advised if medical photographs need to be taken while receiving medical care through Cedars-Sinai Medical Care Foundation. I consent to medical photography, and I understand that images from such photography may be used for my treatment or for the Cedars-Sinai Medical Care Foundation's own healthcare operations, such as peer review or medical education, as Cedars-Sinai Medical Care Foundation or my treating provider(s) deem appropriate. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images. It has been explained to me that the images will be a permanent part of my medical record. At the time a photograph is recommended, I have the option to revoke this consent.

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15. Open Payments database notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

16. Notice to Consumers

Medical doctors are licensed and regulated by the Medical Board of California. For more information, please visit: www.mbc.ca.gov or contact 800-633-2322.

By signing immediately below, I understand that physicians are licensed and regulated by the Medical Board of California.

_____

Patient or legal representative signature

I certify that I have read the foregoing and received a copy thereof. I am the Patient, the Patient's legal representative, or otherwise duly authorized by the Patient to sign the above and accept its terms on his/her/their behalf.

_____

Patient or legal representative name (please print)

_____

Patient or legal representative signature

_____ _____ _____

Date (MM/DD/YYYY) Time Relationship to patient

_____

Staff witness name (please print)

_____

Staff witness signature

_____ _____

Date (MM/DD/YYYY) Time

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Staff to complete the fields below if the patient/surrogate or legal representative is unable to provide in-person signature.

Please indicate how consent was obtained:

❑ Telephone ❑ Verbal ❑ Other: _____

_____ _____

Second witness name (please print) Second witness signature

_____ _____

Date (MM/DD/YYYY) Time

Interpreter/Witness for interpreter

❑ This box shall be checked when the following paragraph is applicable:

We have accurately and completely read the foregoing document to the patient/ legal representative in his/her/their primary language identified below. He/She/ They state that he/she/they understood all of the terms and conditions and acknowledged his/her/their agreement by signing the document in my presence.

_____ _____

Interpreter name (please print)/I.D. no. Interpreter signature

_____ _____ _____

Date (MM/DD/YYYY) Time Language

_____ _____

Witness name (please print) Witness signature

_____ _____

Date (MM/DD/YYYY) Time

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I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the Financial Agreement, Assignment of Health Plan Benefits and Health Plan provisions above.

Financial responsible party name (please print)

Financial responsible party signature

If signed by someone other than the patient, indicate relationship

Date (MM/DD/YYYY)

Time

Witness name (please print)

Witness signature