Southern Indiana Physicians

OUTPATIENT GENERAL CONSENT FORM

This consent applies to Indiana University Health Southern Indiana Physicians, its agents, associates, as well as providers. In each paragraph IU Health Southern Indiana Physicians refers to all IU Health Southern Indiana Physicians practices. In each paragraph doctors, independent doctors, residents, fellows, nurse practitioners, and physician assistants will be called providers.

I agree to let IU Health Southern Indiana Physicians, its agents, associates, as well as providers give me medical and surgical care. This includes tests, blood tests, exams, anesthesia, procedures and drugs which are necessary for the diagnosis and treatment of my medical condition according to the judgment of my treating provider.

I agree that IU Health Southern Indiana Physicians cannot make any explicit guarantee or promises regarding results or cures.

Teaching Environment: I understand IU Health Southern Indiana Physicians is part of a teaching environment and at times I may be asked to allow students, residents and fellows to be involved in my care.

My data such as demographics, lab results, biopsy results, diagnoses may be used for research. The research may or may not be related to my health care. My data will be carefully treated so I cannot be identified, except as required by law.

I understand IU Health Southern Indiana Physicians has a commitment to research and on occasion, I may be contacted about participation in a research study and that I have the right to opt out from further contact.

Infectious Disease Testing: I agree to allow IU Health Southern Indiana Physicians to test for infectious diseases including hepatitis and human immunodeficiency virus (HIV) if one of my caregivers is exposed to my blood or body fluid. In reciprocity, if I am exposed to any blood or body fluid during my treatment I can request the source person be tested for such infectious diseases in accordance with Universal Protocol; at no cost to parties being tested. All parties involved will have access to results.

Release of Information: I agree to allow my previous health care providers to share my medical records with IU Health Southern Indiana Physicians to provide my health care. I agree that, if I am not competent to speak for myself, or if I so request, IU Health Southern Indiana Physicians may share my medical information with appropriate family members as minimally necessary to make decisions about my care. I agree that as allowed by law, IU Health Southern Indiana Physicians may share my medical records with third-party payors, insurance companies, review agencies, welfare departments, and with third-party data service providers including systems like the Indiana Network for Patient Care (INPC). Patients have the right to opt out, in writing, from this program. This may include records about infectious diseases and drug and alcohol abuse treatment. At any time, I may change my mind about agreeing to this release of information by giving notice to IU Health Southern Indiana Physicians in writing.

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Health Insurance Portability and Accountability (HIPAA): I acknowledge that I have been offered and/or received the IU Health SIP Notice of Privacy Practices.

Pictures: I agree to audio and video recording of my care for IU Health Southern Indiana Physicians use only. I understand no recordings of my care will be made without my knowledge. I will be asked to sign a separate consent if recordings are used for other than treatment purposes.

Personal Belongings: I agree that IU Health Southern Indiana Physicians is not responsible for loss, theft or damage to my personal belongings.

I know that IU Health Southern Indiana Physicians has the right to have any of my things on the premises searched by security or police for the safety and welfare of its patients and visitors. I know if security or law enforcement decides an item could be a threat to health or safety, they may (1) dispose of it, (2) put it in a safe, or (3) confiscate the item(s).

Payment Responsibility: I am responsible for paying for all the care I receive, and if insurance does not cover all the cost, I must pay the remaining balance. I agree IU Health Southern Indiana Physicians may release my medical records as necessary to receive all payments that I am entitled to under insurance policies. I am responsible for knowing what insurance coverage I have and for following insurance policy rules. If I do not pay what I owe IU Health Southern Indiana Physicians, they may send the matter to a collection agency, or attorney and I understand and agree to be responsible for reasonable attorney's fees, court costs, costs of collection and interest.

Duration of Consent: I may revoke this consent at any time except to the extent IU Health Southern Indiana Physicians has already taken action in reliance on it. If I do not revoke it, this consent will continue for one year.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by IU Health Southern Indiana Physicians.

Signature of Patient/Legal Representative	**Date**	**Relationship of Legal Representative to the Patient**	**Date**
Print Patient Name	**Date**	**Signature Adult Witness**	**Date**