



OUTPATIENT SERVICES CONSENT

OUTPATIENT SERVICES CONSENT: I voluntarily consent to care by St. Luke's, its employees and contractors, as well as members of the medical staff who are independent practitioners and not employees or contractors of St. Luke's. Such care includes, but is not limited to, routine x-rays, laboratory and other diagnostic procedures, medical treatment and other medical services as necessary in the treating physician's (or designee's) judgment and normally provided by St. Luke's. This may include the taking of photographs and video that may be useful in treating or diagnosing my condition or that may be useful for medical education purposes or for making a photographic record for my condition.

I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatments or examinations. As a patient of St. Luke's, I understand that individuals being trained in health care may participate in my care. I also understand that health care vendors may be present during my care. I consent to their presence and assistance under general supervision according to St. Luke's policy.

PERSONAL PROPERTY: I understand St. Luke's is not responsible for loss or damage to my personal property brought to St. Luke's.

FINANCIAL CONSENT: I agree to be responsible for payment of all St. Luke's charges. I also agree to be responsible for all professional fees covered by insurance or not. I will submit applications to federal, state and county programs, when appropriate. I understand St. Luke's and its independent practitioners will bill me, my family and/or other responsible parties for services provided.

ASSIGNMENT OF INSURANCE PAYMENT: I voluntarily assign St. Luke's and its independent practitioners the right to pursue their respective claims for reimbursements. I understand claims may be made upon any health insurance policy or policies providing coverage for care and treatment and for physician services rendered.

PATIENT'S RIGHTS AND RESPONSIBILITIES: My signature confirms that I have been provided the St. Luke's Patient's Rights brochure.

Patient's Signature **Date / Time** **Witness Signature** **Date / Time**

The patient is unable to sign because: _____

Signature **Relationship to Patient** **Date / Time**

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of St. Luke's Notice of Privacy Practices on this day or on a previous visit to St. Luke's.

Patient's Signature **Date / Time**

