



CONSENT AND AGREEMENT FOR TREATMENT

Please read the following information carefully. After you have read this Consent and Agreement for Treatment (“Agreement”) please sign your name below to accept the terms of this agreement.

- 1. Authorization for Routine Medical Treatment:** I hereby consent to such medical treatment for myself or my child which in the judgment of my health care provider may be considered necessary or advisable while a patient at Nova Southeastern University Inc., and it’s health care providers, employees and agents (“NSU”).
- 2. Teaching Facilities:** I am aware that the NSU Health Care Centers are teaching facilities, and as a result, medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

I am aware that the NSU Student Medical Center does not involve medical residents, medical students, and other medical career students in my care and treatment. In addition, I am aware that should I access care and treatment at any other NSU Health Care Center for any reason that medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

- 3. Appointments and Cancellation Policy:** The clinic time of the medical resident and clinical faculty is scheduled by appointment. It is essential, that all appointments be kept promptly. When an appointment can not be kept, the clinic must be notified at least 24 hours in advance. Patients that miss THREE (3) scheduled appointments may be DISMISSED from the NSU Health Care Centers. In the event that you are dismissed, the NSU Health Care Centers will be available for emergencies during the normal hours of operation for a period of 30 days from the date of the third missed appointment to provide you with ample opportunity to select a medical provider of your choice.
- 4. Right to Discontinue Treatment:** The NSU Health Care Centers has the right to discontinue treatment. In such cases, the patient or patient’s representative agrees to accept full responsibility for pursuing alternate professional medical care. A

Patient/Representative’s Initials _____

letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of NSU Health Care Centers. Records and X rays will be duplicated upon written request with reasonable charge to the patient.

- 5. Financial Agreement:** I hereby agree to pay usual and customary charges for all services provided by NSU to the patient, except those covered by insurance (which includes all commercial and government third party payors). I understand that I am personally responsible for payment for any non covered services, health insurance deductibles and co insurance. In the event that I fail to fulfill any of the obligations in this section, I agree to pay any and all collection costs incurred by NSU in the enforcement of this section.

- 6. Risks of Treatment:** The students and/or residents under the appropriate supervision of clinical faculty at NSU Health Care Centers are available to answer any questions concerning the potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. In the Student Medical Center clinical faculty are available to answer any questions concerning potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of my treatment.

- 7. Laboratory Bills:** I understand the outside reference laboratory ("laboratory") will bill me directly for all laboratory tests performed by said laboratory. I understand that the fee schedule and/or cost for laboratory tests performed by NSU shall be available to the patient upon request.

- 8. Patient Records:** I understand that all original records and diagnostic aids, such as x rays, are the property of NSU Health Care Centers. I understand that NSU Health Care Centers will own the original records. I also understand that I may obtain copies of the records at a reasonable cost, upon written request, based upon established policies of NSU Health Care Centers.

- 9. Consent to Photograph:** I understand that photographs may be taken to document and assist with my care. I understand that NSU Health Care Centers will own these images. I also understand that I may obtain copies of the images at a reasonable cost, upon written request, based upon established policies of NSU Health Care Centers.

- 10. Release of Information:** I hereby authorize and consent to NSU to release medical information to obtain payment as described in the NSU Privacy Notice. This authorization will include where applicable psychiatric, alcohol, drug abuse

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and laboratory results of HIV Infection (Human Immune Deficiency Virus) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). I also authorize release of information to any and all regulatory and/or accrediting organizations as necessary to the NSU Health Care Centers to maintain its accredited status.

11. Change of Student/Resident/Clinical Faculty: I understand that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member and/or student(s) or resident(s) actually are involved in performing the care and treatment. In addition, I understand at the Student Medical Center that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member is involved in performing the care and treatment.

12. Information for Female Patients: I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing conception and pregnancy. I have been advised that in addition to using my regular birth control pills that I will need to use and an additional alternative method of birth control while taking medications prescribed during my care and treatment.

13. Medical History and Follow up: I acknowledge that I have provided an accurate and complete a medical and personal history, including antibiotics, drugs, or other medications I am currently taking as well as those which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x rays.

14. Assignment of Benefits: I hereby irrevocably assign and transfer to NSU all right, title and interest in any benefits payable to which I may be entitled from all insurance companies, employee benefit plans, third party administrators and/or other person or entities financially responsible for my medical care and treatment rendered to me, my dependent or the insured by NSU. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf to NSU. Where Medicaid benefits are applicable, I certify that I am a recipient of Medicaid benefits and request that said payment of authorized benefits be made on my behalf to NSU.

Patient/Representative's Initials _____

I certify that I have read and understand the preceding Consent and Agreement for Treatment, and/or have asked and had answered to my satisfaction, any and all questions that I may have about same, by my treating student/resident or clinical faculty physician.

Patient or Patient Representative Signature

Date

Print Name of Patient or Patient Representative

Patient Date of Birth

Description of Patient Representative's Authority

Confirmation of interpretation to Patient (if applicable)

If the patient does not read/understand English, it is the responsibility of the person who is authorized by him/her to ensure that the content of this consent form has been duly explained to him/her before he/she signs the form.

- The Patient does not read or understand English.
- I confirm that I understand the content of the consent form and I have interpreted and explained the content of the form to the patient so that he/se clearly understood what it meant before signing it.

Print Name of Interpreter

Relationship to Patient

Signature of Interpreter