



Patient Name (PTNM):

Medical Record Number (MRN):

**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 Care Foundation. 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.

**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 co-payments and charges for services which are not covered by my insurance.

**COPAYMENT POLICY:**

If applicable, at the time of check-in, I will be required to pay a co-payment. If I do not pay my co-payment, I understand that my visit may be cancelled.

**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.

**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.

**ANCILLARY SERVICES:**

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

**RELEASE OF INFORMATION:**

I authorize the release of my medical records or other information necessary to provide health care, to process my medical claims, and for other purposes relating to the health care 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.



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**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.

**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 the forms include but are not limited to: jury duty excuse, Family Leave Act application, accident reports, and school and camp forms. There may be other forms with associated fees.

**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 complete 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(s) attempt 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.

**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.

**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.

**PATIENT PHOTOGRAPH:**

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.

Patient Initials: \_\_\_\_\_



\_\_\_\_\_  
Today's Date (PRINTDATE):

\_\_\_\_\_  
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\_\_\_\_\_  
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**FOR MEDICARE PATIENTS ONLY**

I am aware that my physician is participating in a Medicare Accountable Care Organization. The goal of the ACO is for my physician to communicate closely with my other health care providers to deliver high-quality care and meet my unique individual needs. If I have further questions about this, I understand that I can contact Cedars-Sinai Patient Services at 1-800-700-6424.

Patient Initials: \_\_\_\_\_

**I certify that I have read and fully understand the above.**

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date:

**If a minor, signature, name and date of parent/guardian:**

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date: