

Client Number: _____



**LMU-DeBusk College of Osteopathic Medicine
Department of Outpatient Services
University Medical Clinic**

165 Westmoreland Street, PO Box 4408
Harrogate, Tennessee 37752 (O) 423-869-7193

Consent for Treatment and Responsibility for Payment

I, _____, give my consent for medical treatment by the Department of Outpatient Services for **myself/my child** including any laboratory services or specialty testing which may be necessary in delivering appropriate medical treatment.

I acknowledge payment is due the Department of Outpatient Services upon completion and in consideration of the services rendered to me as a client. I also understand some or all of the payment due for services rendered *may* be my responsibility (i.e. self-pay obligation, deductible, or coinsurance responsibility or non-covered services liability). I agree overpayments collected on services provided may be applied directly to an unpaid account which is the responsibility of the patient or the responsible party at the time of overpayment.

I understand independent contractors *may* provide professional services for the Department of Outpatient Services who are not employees or agents of the Department of Outpatient Services. These independent providers may bill separately for their services and at rates they establish.

I acknowledge there may be times when a Trainee, including but not limited to a Resident Physician, Medical/Nursing Student or Physician Assistant Student who, in their academic rotations, may be responsible for providing care in Outpatient Services. I have the option of refusing the Trainee's presence in the examination room while I am being treated.

I agree to have a Trainee in the exam room: ***I do not agree to have a Trainee in the exam room:***

The Department of Outpatient services is part of a teaching institution and may utilize samples of client testing for teaching purposes. Should I agree to share my information, I understand all personal information will be blinded and my privacy protected from discovery in compliance with HIPAA standards.

I agree to share my medical testing: ***I do not agree to share my medical testing:*** with the College to assist in a teaching capacity.

I hereby authorize the release of information as set forth on this form, for the purposes of benefit payment.

Signature: _____ Date: _____

Receipt of "Notice of Privacy Practices" Written Acknowledgement

I acknowledge I have received a copy of the Department of Outpatient Service's Notice of Privacy Practices.

Signature: _____ Date: _____