Acknowledgement, Assignment and Consent

(Please initial ALL PARTS and sign at the bottom)

Today's Date:	Last Name:	First Name:	DOB:

CONSENT FOR TREATMENT

Initials	
_________	I hereby grant permission to the healthcare professionals of UNLV Medicine to treat and diagnose the above referenced patient as deemed professionally/medically advisable. I further consent to the procedures that may be performed as part of my medical care, such as diagnostic procedures, laboratory procedures, or others.
_________	I understand that UNLV Medicine is a residency program and I agree to the supervised involvement in my medical care by resident physicians and/or medical students. The supervising faculty physician is a medical doctor licensed in the State of Nevada.

INSURANCE ASSIGNMENT

Initials	
_________	I hereby authorize UNLV Medicine to release information necessary to file and/or process a claim with my insurance company.
_________	I hereby authorize the assignment and payment directly to UNLV Medicine for medical services rendered.
_________	I understand that I am financially responsible for all charges not covered by my insurance company, including those resulting from my failure to obtain the necessary referrals and/or authorizations from my primary care and/or referring physician when required.

PHOTOGRAPHY IN DOCUMENTING MEDICAL CARE

Initials	
_________	I understand healthcare providers and UNLV Medicine may use photographs, films, or other records for identification, diagnosis, treatment, education or for other healthcare purposes. Any other uses will require my authorization.
_________	I understand UNLV Medicine will retain ownership rights to these photographs, videotapes, digital and/or other images and that I will be allowed access to view them or obtain copies.
	I understand that these images will be stored in a secure manner to protect my privacy and will be kept for the time period required by law or outlined in the UNLV Medicine Policy.
_________	I must first grant authorization directly or through my legal representative before healthcare providers at UNLV Medicine may use any images or recordings for educational purposes and/or outside the institution that include my personal identifiable health information, including full-face photographic images.

MINORS

Initials	
_________	As parent/guardian of the minor patient, in the event that I am unable to be present, I authorize the person(s) named below to accompany my child for treatment Name ____ Relationship ________________________________ Name ____ Relationship ________________________________
_________	As parent/guardian of the minor patient (16 yrs or older), in the event that I am unable to be present, I authorize UNLV Medicine to provide medically necessary treatment at the discretion of the physician.

OFFICE POLICIES

Initials	
_________	I have received a copy of the UNLV Medicine office policies including but not limited to the Financial and Payment and Prescription Refills.

HIPAA NOTICE OF PRIVACY PRACTICES

Initials	
_________	I understand that the HIPAA Notice of Privacy Practices describes how UNLV Medicine may use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. Please select one of the following by initialing your acknowledgement: ________ I Have received a copy of the HIPAA Notices of Privacy Practices
Office Use Only:	________ Patient/Guardian refused to sign the Notice of Privacy Practices ____ Employee Signature Date

ATTESTATION

I have read and understand the above information and agree to the acknowledgement, assignment and consent as indicated by the initials above.

____

Signature

____

Date

____

Print Name

Relationship to Patient

- ☐ Self
- ☐ Parent
- ☐ Other

____

Specify