

**DOWN EAST COMMUNITY HOSPITAL  
CONSENT TO TREATMENT  
ASSIGNMENT OF BENEFITS**

Down East Community Hospital (DECH) includes its hospital-based physician practices.

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

**General Medical Consent**

**This consent is valid for one year from which it is signed.**

By signing below, I authorize my treating physician, Dr. \_\_\_\_\_, and other healthcare providers or staff that my physician may direct, to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment or therapy deemed by them to be necessary to effectively assess, diagnose and treat my illness or injury. I understand that it is the responsibility of my individual treating health care providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options prior to initiated treatment. I understand that more extensive medical care such as surgery will require additional, separate consent(s) from me. In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my treating health care provider.

**Use and Disclosure of Information**

By signing below, I understand and acknowledge that DECH may use health care information about me for purposes of treatment, payment or health care operations, and may disclose health information about me including mental health-, substance abuse-, and HIV/AIDS related information when necessary for public health and health oversight activities, to ensure the continuation of my care with another provider, for the processing of medical bills with third party payors, utilization review representatives, or financial recovery specialists, and when otherwise required or permitted by law. (A detailed list of permissible uses and disclosures is included in the Notice of Privacy Practices being provided to you). I also understand that DECH may use or disclose limited health information about me to the persons or entities indicated below unless I specifically object to such uses and disclosures:

- I authorize my physician to disclose to an identified family member, other relative, or close friend involved in my care or in the payment of my care any health information about me directly relevant to such person's involvement.

Name(s) of Family Member(s) or Friend(s) Involved in My Care:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- By signing below, I acknowledge that I have received a copy of DECH's Notice of Privacy Practices, which describes in more detail how medical information about me may be used or disclosed and how I can get access to my health care information.

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**Financial Agreement**

By signing below, I understand and acknowledge that I am financially responsible for paying all cost associated with the health care services I receive from DECH. I understand that I may be financially responsible for charges not covered by my health insurance, including deductibles and co-payments, and I agree to make satisfactory arrangements for payment with the Patient Financial Service office upon receipt of a bill. I understand that health information about me may be shared with my health insurance carrier(s) or other third-party payors responsible for paying for my health care. I understand that I may elect to bear the costs of my care privately if I do not want certain sensitive health information disclosed to my third party payor. By signing below I assign my health insurance benefits to DECH, and authorize my health insurance carrier(s) or other third party payors responsible for paying my health costs, including Medicare and MaineCare, to pay the costs associated with my healthcare directly to DECH

Notice of Disclosure of Information When Treatment Provided to a Minor: Minors who consent to health care services on their own behalf, but whose services are reimbursed under a parent's insurance policy, are hereby informed that their parents(s) will received an Explanation of Benefits describing the nature of the services provided. Consequently, services provided to a minor under a parent's insurance policy may not be confidential.

**I have read, understood and agree to the information provided above. I have had the opportunity to have my questions answered to my satisfaction. I understand that I may have a copy of this consent upon request.**

**If I am not the patient, I certify that I am authorized by law to consent to the above provisions on the patient's behalf.**

\_\_\_\_\_  
**Patient or Authorized Legal Representative \***

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Authorized Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Authorized Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Authorized Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient or Authorized Legal Representative**

\_\_\_\_\_  
**Date**

If signed by an authorized legal representative, please indicate legal authority

- Parent
- Power of attorney
- Guardian
- Other: \_\_\_\_\_