Community Health Systems, Inc. (CHSI)
Patient Consent Form

CONSENT ITEMS	PATIENT INITIALS
CONSENT FOR TREATMENT: I hereby authorize medical treatment for the below named.	
RIGHTS AND RESPONSIBILITIES: I hereby acknowledge that I have received a copy of CHSI's Patient Rights and Responsibilities. I further acknowledge that I will be offered a copy of any amendments upon request.	
CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE: I hereby acknowledge that I have been given information regarding advance directives.	
HIPAA – NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of CHSI's HIPAA - Notice of Privacy Practices. I further acknowledge that a copy of the current notice is made available / posted in the waiting area, and that I will be offered a copy of any amendments upon request.	
MEDICAL HISTORY: I hereby authorize CHSI to access my medical history, without limitation or exclusion, as is required and / or reasonably advisable to disclose, process, retrieve, transmit, and view my medical history.	
INSURANCE: I hereby authorize and request my insurance company to pay CHSI directly for my claims. I understand that my medical insurance carrier may pay less than the actual bill for services rendered and I agree to be responsible for any unpaid balances I or my dependents may incur.	
I acknowledge that I have been informed that CHSI is federally funded and because of that they are required to ask me for my family size and income on a yearly basis. I have elected to either provide staff with my family size and estimated gross yearly income OR elected not to provide the information.	
I certify that I have read and understand this notice / authorization. I have been given an opportunity to ask any questions I may have regarding this notice. I acknowledge that my questions, if any, have been answered to my satisfaction. I understand that I may revoke this authorization at any time by written notice, except where information has already been released.	
I acknowledge receiving a copy of this document.	

Patient's Name (print): _____ DOB: _____

Signature of patient/guardian: _____ Date: _____

If not signed by the patient, please indicate the relationship: _____

Staff Use Only

Notice of Privacy Practices not Obtained

To be completed by CHSI when a patient's signed Acknowledgement form is not obtained.

Please check the box that best applies:

☐ Individual refused to sign.

☐ An emergency situation prevented us from obtaining the acknowledgement.

Comment: _____