Patient Name: _____
Account #_____
Date of Birth: _____

Consent for Treatment

- I consent to Lakeview providers and healthcare workers treating me or the above patient. Treatment could include (but is not limited to) lab tests, X-rays, immunizations, prescriptions, or other procedures. I understand I have the right to refuse treatment.
- Lakeview Providers may have students in training programs supervised by licensed healthcare providers participate in my care. I may decline to involve these individuals in my care, which will not affect my care or treatment.
- I understand that while receiving care, a healthcare worker could be exposed to my blood or bodily fluids. If this rare event occurs, I consent to blood testing for infectious diseases to protect the healthcare worker.

Code of Conduct

- Lakeview Clinic cares about our patients and the staff who provide care. We ask that all patients be respectful when engaging with our team members. Offensive comments, physical or verbal threats or assaults, sexual or vulgar words or actions, or disrupting other patients' care or experience will not be tolerated and could result in discharge from Lakeview.

Authorization to Assign Benefits

- I request that authorized benefits be paid directly to Lakeview on my behalf for services provided at Lakeview Clinic or by a Lakeview Clinic provider at another location.
- I authorize any holder of medical or other information about me to release to Lakeview, Medicare and its agents, any insurance company, any third party payor state medical agency, or any other governmental or private payor responsible for paying such benefits any information and health records needed to determine these benefits or benefits for related services.

Third-Party Billing

- I understand Lakeview contracts with third-party providers and laboratories to perform and interpret laboratory tests and imaging results. Sometimes, these providers & laboratories will bill directly for these services. I consent to Lakeview sharing insurance and demographic information for these services.

Release of Information

I permit Lakeview and its agents (including Business Associates) to share and access my health information for treatment, payment, and healthcare operations, as described below:

- Lakeview may share my medical information with other healthcare professionals, facilities, and anyone else it believes is involved in my care, treatment, case management, discharge planning, or related services.
- Lakeview may access my current prescription history through pharmacy databases and my current prescription history of controlled substances in any state database, such as the Minnesota Prescription Monitoring Program, where the law requires consent.
- Lakeview May share my medical information and account records with my health plans and payers, their agents, and others as needed for payment purposes (such as eligibility and coverage determinations, billing, processing claims, coordinating benefits, and utilization review) and as otherwise required by my health plan or another payer.
- Lakeview may share my medical information with others (where consent is required) to improve the quality of my care and experience and to manage its business operations, including sharing my information with accrediting and quality organizations, regulatory agencies, and public health agencies responsible for licensing and accreditation, fraud investigation, care management, immunization tracking, public health reporting, drug and device defects or recalls, and quality evaluation.
- I consent to treatment via telehealth. I understand Lakeview might use third-party, web-based video conferencing vendors to aid in real-time treatment sessions with my healthcare provider and electronically transmit my health information.

Notice of Privacy Practices

- I can find a copy of the current privacy practices at the front desk, posted in the registration area, and on www.lakeviewclinic.com. I can ask for a copy of this notice anytime.
- I understand this consent ends one year from the date of signature, except for payment purposes.
- I understand that I may take back permission by notifying Lakeview in writing. No further release will take place after the date notified.
- I understand that other parties may disclose health information received from Lakeview.
- This form will be available in my electronic medical record, and I may ask for a copy at any time.

By signing, I am indicating that I understand and accept the terms on this form.

- If the patient is 18 or older, the patient must sign and date the form.
- If the patient is 18 or older and unable to sign, a legally authorized person must sign and date this form.
    - State your authority and provide legal documentation if not already on file:

  ☐ Legal guardian or Conservator ☐Health Care Agent (Power of Attorney) ☐Other legal representative _____
- If the patient is 17 or younger, the patient's parent or legal guardian must sign and date this form unless an exception exists under state or federal law. State your relationship:_____

Signature _____ Date_____