IDAHO PHYSICAL MEDICINE AND REHABILITATION, PA

CONSENT AND CONDITIONS OF TREATMENT

Patient Name: _____
Birth Date: ____/____/____

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment of the Patient by Idaho Physical Medicine and Rehabilitation, P.A. ("IPM&R") and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. If IPM&R personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of Patient for any blood-borne disease for the protection of IPM&R personnel.

ADVANCE DIRECTIVES ***(APPLIES ONLY TO PATIENTS RECEIVING TREATMENT IN THE IPMR AMBULATORY SURGERY CENTER (ASC))***
Please indicate whether the Patient has executed an advance directive, e.g.:
[ ] Living Will [ ] Durable Power of Attorney [ ] POST [ ] Other (describe): _____
I understand that it is IPM&R's *Ambulatory Surgery Center* policy not to comply with advance directives that would prohibit life sustaining treatment. I consent to such treatment on behalf of the Patient, and agree that any contrary directions in the Patient's advance directives shall be suspended while the patient receives care at IPM&R Ambulatory Surgery Center.

CONDITIONS FOR TREATMENT AT IPM&R. In consideration for the care and treatment that Patient will receive or has received at IPM&R, I agree to the following:

1. Patient Responsibilities. I agree to comply with the Patient Responsibilities set forth in IPM&R's separate Notice of Policies, Patient Rights, and Patient Responsibilities.

2. Payment. I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and IPM&R. I agree to make such payments according to IPM&R's regular terms of payment. Where appropriate, I agree to submit and cooperate with IPM&R in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to IPM&R's policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.

3. Assignment. I hereby assign and authorize direct payment to IPM&R of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full.

4. Billing Practices. I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. IPM&R may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that IPM&R will require payment of all accounts at the time the services are rendered unless IPM&R has expressly agreed to contrary arrangements. Where insurance is available, IPM&R will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

PERSONAL PROPERTY. I understand and agree that IPM&R does not assume any responsibility for my personal property and shall not be liable for any loss or damage to such personal property.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at IPM&R.

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[OVER]

PERSONS FOR WHOM IPM&R IS NOT LIABLE. I understand that IPM&R is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by IPM&R may be involved in my care or treatment, including but not limited to members of the medical staff of IPM&R's ambulatory surgery center, independent contractors, vendors, or product technicians. I understand that IPM&R is not liable for the acts or omissions of non-employees or IPM&R employees acting outside the course and scope of their duties.

NOTICE OF PRIVACY PRACTICES. I have received a copy of IPM&R's Notice of Privacy Practices on this or a prior occasion. [Please Initial]: _____

NOTICE OF PATIENT RIGHTS AND PATIENT RESPONSIBILITIES. I have received a copy of IPM&R's Notice of Policies, Patient Rights, and Patient Responsibilities on this or a prior occasion. [Please initial]: _____

OWNERSHIP DISCLOSURE, Idaho Physical Medicine and Rehabilitation, PA is owned by:

Robert H. Friedman, MD.	Nancy E. Greenwald, MD	Christian G. Gussner, MD
Mark J. Harris, MD	Monte H. Moore MD	Barbara E. Quattrone, MD
Michael O. Sant, MD		

[Please initial]: _____

QUALITY CONTROL AND INFECTION CONTROL, IPMR maintains a monitoring program designed to prevent, control and investigate infections and communicable diseases as set forth by nationally recognized infection control guidelines. We do this by using quality assessment and performance improvement plans.

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

_____ _____
(Print Name) (Date)

_____
(Signature)

_____
Relationship to Patient/Authority