axiscommunityhealth

INFORMED CONSENT FOR MEDICAL TREATMENT

I, _____, hereby authorize Axis Community Health affiliated physicians, providers, and staff to administer medical treatment, which may now or during the course of care be deemed advisable or necessary.

I acknowledge that I am legally responsible for all charges in connection with medical care and treatment provided by Axis Community Health. Treatment charges may include, but are not limited to: provider visits, nurse visits, lab tests, medications, supplies, and equipment.

I am also responsible for understanding my insurance and/or health care program coverage and restrictions and for immediately notifying Axis Community Health whenever there is a change in information necessary to process the claims.

I understand that I have a right to file a complaint/grievance if I am not comfortable with medical decisions that directly affect me. I have the right to appeal to supervisory staff or the Chief Operating Officer.

I understand I have a right to file a complaint/grievance directly with regulatory agencies even if I have not filed one with Axis. My decision to file a complaint/grievance will not compromise my care. All information regarding the complaint/grievance will be kept confidential.