

**KANSAS UNIVERSITY PHYSICIANS, INC.  
CONSENT FOR MEDICAL CARE**

Recognizing the need for medical care for the patient whose name appears on this form, I do voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by the medical staff of Kansas University Physicians, Inc. and their assistants or designees as is necessary. I understand that, other than in the case of emergency treatment, I will have the opportunity to participate in the process by which decisions are made about the patient's care. I also understand that I will be asked to sign separate consent forms for the authorization of any non-routine procedures and treatments the patient might require.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of the examination or medical treatment of Kansas University Physicians, Inc.

I understand that Kansas University Physicians, Inc. has teaching responsibilities through its affiliation with the University of Kansas Medical Center and give my permission for the involvement of health care students, residents and other medical personnel for educational purposes. Furthermore, I give my consent that all tissues and specimens obtained, which would otherwise be discarded, may be used for research and/or teaching purposes when they do not identify me as the patient. I also understand that I may be asked to sign additional and separate authorization forms for clinical research and research using tissue specimens that will identify me as the patient.

I authorize Kansas University Physicians, Inc. to furnish requested information or excerpts from the patient's record to any insurance company, health plan or sponsoring agency who may be providing financial assistance for medical care (as well as any agents or review agencies necessary for processing any claim), including Medicare and Medicaid, for the purpose of obtaining payment; and to any physician, hospital, laboratory, radiological facility or other health care provider from which the patient has been referred or to which the patient is being referred as is necessary to support continuity of care. I understand that these medical records may include all information relative to the patient's physical condition, past and present, including the diagnosis and history of the patient's case, psychiatric history and alcohol or drug abuse information. I understand that the way Kansas University Physicians, Inc. may use this information is described under the Notice of Privacy Practices for KU Medical Center, of which I may request a copy at anytime.

I authorize payment of medical benefits to the Kansas University Physicians, Inc. for services provided to the patient. I also authorize payment of government benefits to Kansas University Physicians, Inc.

I accept full financial responsibility for services received by the patient which are not covered by government benefits or any type of insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to Kansas University Physicians, Inc. at the time of services. I also understand that I am responsible for obtaining all referrals or authorizations required by my insurance.

**MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND AM AUTHORIZED TO CONSENT FOR MEDICAL CARE OF THE PATIENT NAMED BELOW.**

Patient's Name: \_\_\_\_\_

Signature of Patient or Authorizing Person:

Signature of Witness

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Clinic

Authorization must be signed by the patient, by a parent if the patient is a minor, or by a guardian if the patient is incapacitated.