altheda MEDICAL CENTER

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# AGE OF MAJORITY TRANSITION ACKNOWLEDGMENT & AUTHORIZATION

## ACKNOWLEDGMENT OF TRANSITION TO ADULT STATUS

I acknowledge that I have reached the age of 18 and am now legally responsible for my own healthcare decisions. I understand that:

- I am the sole decision-maker regarding my medical care.
- My parent(s) or prior guardian(s) no longer have automatic authority to consent to treatment on my behalf.
- My parent(s) or prior guardian(s) no longer have automatic access to my medical records or protected health information.
- Altheda Medical Center will rely exclusively upon my consent and authorization for treatment and disclosure of information.

I acknowledge that Altheda Medical Center is entitled to rely upon my representations regarding my identity, contact information, insurance coverage, and financial responsibility unless and until I provide written notice of changes. Patient Initials: _____

## ADULT CONSENT TO TREAT

I voluntarily consent to receive healthcare services from Altheda Medical Center and its physicians, certified registered nurse practitioners, physician assistants, behavioral health providers, employees, contractors, affiliates, successors, and assigns.

I authorize the provision of any and all healthcare services within the lawful scope of practice of its licensed providers, as determined in the professional judgment of the treating clinician, including in-person services, telehealth services, and any additional healthcare services offered now or in the future. I understand that the practice of medicine and behavioral health is not an exact science and that no guarantees or assurances have been made regarding outcomes. Patient Initials: _____

## FINANCIAL RESPONSIBILITY AGREEMENT

I acknowledge that I am financially responsible for all charges related to services rendered to me, regardless of insurance coverage status.

If insurance information is provided, I authorize Altheda Medical Center to submit claims on my behalf. I understand that insurance coverage does not guarantee payment and that I remain responsible for any balances not paid, denied, reduced, or otherwise unpaid by the insurer, including deductibles, copayments, coinsurance, non-covered services, or services determined not medically necessary by the insurer. I understand that disputes with my insurance carrier or family members do not relieve me of financial responsibility for services rendered in reliance upon my consent.
Patient Initials: _____

## HIPAA RIGHTS ACKNOWLEDGMENT

I understand that my protected health information will not be disclosed to any person, including my parent(s), without my written authorization, except as permitted or required by law. If I wish to authorize another individual to receive medical information, participate in care discussions, or access my medical records, I must complete a separate written Authorization for Release of Protected Health Information form. Patient Initials: _____

## CONFIRMATION OF CURRENT INFORMATION

I confirm that the following information is accurate and current:

Address: _____ Phone Number: _____ Email: _____

Emergency Contact: _____ Insurance Subscriber & ID #: _____

I agree to notify Altheda Medical Center promptly of any changes to my contact information, insurance coverage, or financial responsibility.

I certify that I have read and understand all sections of this Age of Majority Transition Acknowledgment & Authorization and agree to its terms in full.

**Patient Printed Name:** _____ **Date of Birth:** _____

**Patient Signature:** _____ **Date of Signature:** _____