Cochlear Implant Center
6535 North Charles Street, Suite 250
Baltimore, Maryland 21204
(443) 849-8400

Patient Consent Form

Please carefully read the information contained in the Patient Information Package.
Be sure to ask for clarification of anything that you don't understand or may have a concern about.
Then, please check the items you consent to and sign and date this form on the back

1. **Authorization for Treatment:**

   ☐ I authorize my GBMC physician to provide medical treatment to the patient named on this consent form.

2. **Financial Policy**

   ☐ I have read and understand the information provided on the GBMC Financial Policy.
   ☐ I understand that I am responsible for any deductibles, co-insurance or co-payments associated with my insurance policy and for payment of services not covered by my insurance policy.
   ☐ By signing this form, I authorize payment of insurance benefits otherwise payable to me, to be paid directly to GBMC.
   ☐ I understand that it is my responsibility to contact my insurance company for pre-certification of medical services as required by my insurer.

3. **Notice of Privacy Practices**

   ☐ I certify that I received the GBMC Notice of Privacy Practices.
   ☐ I authorize my GBMC physicians to disclose any health information (including information psychiatry, drug abuse, alcoholism or HIV testing) for my treatment, related to payment for services and associated care, and in routine health system operations.

4. **Authorization for Release of Protected Health Information to a Spokesperson**

   ☐ I have read and understand the GBMC Spokesperson information.
   ☐ I do NOT want my information released to any Spokesperson.
   ☐ I authorized GBMC to tell the spokesperson(s) named below about my x-ray, laboratory, test findings, diagnosis, prognosis and treatment plans either in person or by telephone.

Spokesperson Information: (please print clearly)

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

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5. Consent to Photograph (please select one option)

☐ I authorize GBMC to photograph, or permit other persons in the employ of this facility to photograph, the person named on this form for identification purposes only.

☐ I decline to be photographed.

_____ _____

Signature of Patient or Guardian **Relationship to Patient**

_____ _____

Print Name of Patient or Guardian **Date**