



## MEDICAL TREATMENT AGREEMENT (MTA)

Patient or the patients' legal representative agree to the following terms of encounters with one or more: Providers of Banner Health (which for purposes of this MTA includes Banner Urgent Care, Banner Medical Group, Banner University Medical Group, Banner Research, and Banner Alzheimer's Institute) and/or in one or more Banner Health facilities:

1. **Medical Treatment:** The patient consents to the treatment, services and procedures which may include but are not limited to laboratory procedures, X-ray examinations, telemedicine services, medical and surgical treatments or procedures, anesthesia, neuropsychological testing, behavioral health evaluation, treatment and/or counseling.
2. **Teaching Program:** Banner Health provides training programs for Providers and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of Providers or other Banner Health employees. These persons in training may also observe care given to the patient by Providers and Banner Health employees.
3. **Contraband:** Drugs, alcohol, weapons and other articles specified as contraband by Banner Health may not be brought onto Banner Health premises. Any illegal substance will be confiscated and turned over to law enforcement authorities:
4. **Photographs/Videos/Taped Therapy Sessions:** I understand and agree that photographs and/or videos may be take of me upon admission for identification purposes or for security, educational and/or quality improvement purposes. I further agree that all photographs and tapes will remain the property of Banner Health. I will not audiotape, videotape or take pictures of other patients and will not audiotape, videotape or take pictures of Banner Health staff without their permission.
5. **Communication:** Call this number \_\_\_\_\_  
 Okay to leave a message      Do not leave a message      Do not speak to family members.

I authorize the following individuals to inquire and receive verbal information regarding my care.

\_\_\_\_\_

6. **Term of Agreement:** This agreement shall remain in effect as long as I am seeking services from Banner Health. I will be asked to sign a new agreement every year. This release shall continue for so long as the medical and/or financial records are needed for payment, treatment or healthcare operations.
7. **Dismissal from Provider or Banner Health and/or Banner Health Provider:** Banner Health and/or Banner Health Provider may dismiss a patient for reasons that include but are not limited to excessive no-shows, non-compliance with treatment recommendations, or disruptive or inappropriate behavior.

**Release of Information:** The patient acknowledges and agrees that medical and/or financial records (Including information regarding Behavioral Health alcohol or drug abuse, HIV related or to other communicable disease related information) may be provided to the following:

- A. Healthcare providers or their agents who are providing or have provided health care to the patient; any individual or entity responsible for payment of Banner Health's charges; to health care providers or organizations accrediting the facility or conducting utilization review, quality assurance, or peer review; and to Banner Health provider's or Banner Health's legal representatives and professional liability carriers.
- B. Individuals and organizations engaged in medical education and research, provided that information may only be released for use in medical studies and research without patient identifying information.
- C. Individuals and entities as specified by federal and state law and/or in Banner Health's Notice of Privacy Practices.
- D. Patient records of services provided at any Banner facility including Banner Medical Groups or Banner Hospitals, Surgicenters, Hospices, etc. may be exchanged among these facilities to provide appropriate patient care.

### ACKNOWLEDGMENT

Initial  
 If applicable in the state where I am receiving care, I acknowledge receipt, and have read and understood the information regarding the State/Regional Health Information Exchange/CommonWell or I previously received this information and decline another copy.

I have received the Notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

\_\_\_\_\_  
Patient / Parent of Minor Child / Court-Appointed Guardian /  
Patient-Appointed Agent / Statutory Surrogate (Please circle the Correct Title)     Witness \_\_\_\_\_  
Date \_\_\_\_\_



\*10050020\* Registration

1005-0020  
(10/2018)