memorial regional health

Memorial Regional Health Consent for Treatment

1. GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES:

I consent to treatment/admission to the Facility. I permit the Facility and its employees, physicians, fellows, residents, interns, and others involved in my care to treat me in ways they judge to be beneficial to me. I have a right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when health care personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments given by my physician, consulting physicians, fellows, residents, interns, and their associates and assistants, or given by Facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I have been informed of the treatment/procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by a physician or one or more additional physicians, fellows, residents, interns, and employees of the Facility, who may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment. I agree and understand that all individuals involved in my care are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for their acts or omissions. Services may be performed by independent contractors who are not employed by the Facility. I am aware the practice of medicine is not an exact science and understand that no guarantee has been or can be made for the results of treatments, care or examinations in the Facility.

I consent to the photographing, videotaping and/or video monitoring, of appropriate portions of my body, for medical and medical record documentation purposes, as long as such photographs or videotapes are maintained and released in accordance with protected health information regulations. I consent to virtual health/telemedicine services as part of my treatment. I understand that “virtual health” or telemedicine services include the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that medical, nursing, and other authorized health care providers in training may be observing and participating actively in my care under the supervision of authorized personnel. I give my consent to such observations and/or participation.

2. ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:

I assign and authorize payment directly to the Facility, and to any Facility-based physician, all insurance benefits, sick benefits, injury benefits, or proceeds of claims resulting from the liability of a third party unless my account is paid in full when I am discharged or finish my outpatient care. If I am eligible for Medicare, I request Medicare services and benefits. I agree this assignment will not be withdrawn until my account is paid in full. I understand I am responsible to pay any account balance not covered by my insurance company in accordance with the regular rates and terms of the Facility.

If I do not make payments when due and the account is turned over for collection, I agree to pay all collection agency fees, court costs and attorneys’ fees. I also agree that any patient or guarantor overpayments may be applied directly to past due account. I consent for the Facility to work on my behalf with my insurance company/companies to get authorization or appeal any denial for reimbursement, coverage, or payment for services or care provided to me.

3. NURSING CARE:

The Facility provides only routine nursing care. Private duty nursing is not provided but may be arranged directly between an agency and me at my expense. I release Facility from any and all liability arising from the fact that I am not provided private nursing care.

Initials: _____

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4. EMTALA:

The Facility must treat medical emergencies regardless of my ability to pay. If I or my guarantor have a medical emergency or if I am a pregnant woman in labor, I have the right to receive, within the capabilities of this Hospital's staff and facilities, an appropriate medical screening exam, stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance or am not eligible to receive Medicare or Medicaid.

5. PERSONAL VALUABLES:

I understand that the Facility is not liable for the loss or damage to any articles of personal valuables unless I have given them to the Facility to be put in the safe and been given a receipt by Facility for their safe return. At no time will the Facility be responsible for more than $500 for my deposited items.

6. WEAPON / EXPLOSIVES / DRUGS:

I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate, including giving them to law enforcement.

7. CONSENT TO RELEASE HEALTH INFORMATION:

I understand this Facility uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future healthcare providers. I agree that this health information may be released through the Facility's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Facility; (2) to my past, current and future healthcare providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Facility). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

8. NOTICE OF PRIVACY PRACTICES:

I have been offered a copy of the Facility's Notice of Privacy Practices and consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

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9. RESEARCH STUDIES:

Please initial:____Yes ___No

Are you currently a participant in any research study or project?
If yes, please briefly describe what is being studied (drug, medical device or other)

_____

Who can the Facility contact with questions about the study?

_____

_____

10. CELL PHONES:

I consent to provide my telephone number(s), including my wireless telephone number(s), so representatives from the Facility, its successors or assigns can contact me in any manner including phone call, automated telephone dialing system or an artificial or prerecorded voice, text, or email, about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand if I incur any cost from being contacted at the telephone number(s) provided to the facility, including not limited to data, roaming, additional minutes or other fees, the facility is not responsible for paying these charges. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. EXTERNAL PHARMACY:

I consent to the exchange of prescription information between the facility and my pharmacy(ies).

12. VIDEOTAPING/RECORDING:

I agree not to photograph, video record, audio record, or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure my visitors comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me), the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

_____

Patient's Signature or Legal Representative Date/Time

_____

Relationship to Patient Interpreter, if Utilized Date/Time

_____

Witness Signature Date/Time

_____

If Telephone Consent, Second Witness Signature Date/Time

Initials: _____

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