CONSENT FOR INPATIENT/OUTPATIENT TREATMENT FOR HAMILTON MEMORIAL HOSPITAL DISTRICT (HMHD)

AUTHORIZATION FOR RELEASE OF INFORMATION AND GENERAL CONDITIONS FOR ADMISSION

I believe I have a condition requiring health care services for the purpose of diagnosis and/or medical/surgical treatment. I consent to the provision of medical and/surgical care by my provider, consulting physicians, and other health care providers. Such care may include, but is not limited to, diagnostic and therapeutic tests and procedures and treatment as may be ordered by my provider, and/or his/her designees including consulting physicians. This consent includes, but is not limited to, the performance of invasive diagnostic procedures, administration of fluids, blood and/or blood products/components, medications and any radiology procedures.

I UNDERSTAND

2.1 The practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this facility.

2.2 It is customary, except in emergency circumstances, that no substantial procedures will be performed upon a patient unless, and until, he/she has had an opportunity to discuss them with the provider or other healthcare professional to the satisfaction of the patient. I have the right to consent or refuse consent to any proposed procedure or therapeutic course.

2.3 No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

2.4 Providers on staff at this facility, including but not limited to, the emergency physicians, pathologist, radiologist, and other hospital-based providers and consulting physicians are **NOT** employees or agents of the District. Such providers are independent contractors who have been granted the privilege of using this facility for the care and treatment of their patients. I recognize that these providers exercise their own independent medical judgment and they are not subject to the supervision or control of the District with respect to my treatment. K Murugappan, MD; J Chamness, PA-C; D Burns,PA-C; L Devous, FNP-C; H Johnson, AGACNP-BC, FNP-C; S Stout, FNP; D Vaughn,FNP-C; Jamie Jacobs, FNP-C and Emily Harris, PA-C **are** employees of HMHD. I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of HOSPITAL for my care.

Patient initial here

2.5 Any authorization or consent that I have given may be cancelled or revoked by me in writing up until the time of treatment.

2.6 I have a right to express a concern or grievance regarding any quality of care issue, either informally or formally, through the patient grievance mechanism established by the District.

2.7 I am aware that among those who will be attending patients at this facility there are medical, nursing and other health care personnel who are in training. Unless I direct otherwise in writing, such personnel may be present during patient care, assisting in or providing care, as part of their education.

2.8 I understand that the hospital and the independently contracted providers who provide care at this facility use a joint Notice of Privacy Practices to comply with federal and state privacy rights and protections for patients. I further understand, acknowledge and agree that the use of a joint Privacy Notice rather than the use of separate notices and forms from the District and the providers, is solely for my convenience as a patient and to improve my access to the separate health care services that the District and the providers independently provide. I also understand, acknowledge and agree that by signing this consent the providers who provide care at this facility are independent contractors and are not agents, servants or employees of the District, unless otherwise identified; the providers exercise their own medical judgment in treating me otherwise providing professional services tome; the providers are solely responsible for their own compliance with state and federal privacy laws; and nothing in the privacy notice is meant to imply, infer or create any agency or employment relationship between the providers and the District, whether actual or implied, nor does the privacy notice alter, limit or modify any other consents for treatment or procedures I may sign during the time I am provided care at this facility.

2.9 I understand and agree that money, jewelry and other valuables should not be brought into the facility. If I do bring them into the facility, I agree to notify nursing staff. Such valuables should be deposited with the facility or sent home by me with a responsible person. I agree that I will not hold HMHD liable for the loss or damage to any money, jewelry, glasses, dentures, documents, clothing or property of any kind and description that I maintain in my possession.

2.10 In the event I am transferred to another health care facility, or require services such as home health care, for the continuity of care purposes, I authorize HMHD to release information and/or copies of my medical record, or portions thereof, to such other health care facilities and/or providers in the event of such transfer. I further authorize any provider and the facility to which I am transferred to provide information to HMHD upon request of the hospital regarding care, condition and treatment.

3. In the event a health care provider sustains exposure to my blood or body fluids, I give permission for a sample of my blood to be drawn and tested for infectious diseases of any nature and description.

RELEASE OF INFORMATION

4.1 I authorize HMHD to release and/or send any medical information deemed by it to be necessary for the processing and payment of my hospital bills to an insurance company or other third party payer who is or may be responsible for paying any part of my medical treatment. I understand that this information may include the diagnosis of, and treatment for, mental illness, drug and alcohol abuse. This release includes the results of any blood tests that may be performed to determine the presence of the Human Immunodeficiency Virus (causative agent of AIDS). I understand that this authorization is furnished to enable the District on behalf of itself, the providers for whom the District is authorized to bill, and also providers who bill on behalf of themselves and myself, to obtain or attempt to obtain proceeds, benefits or amounts due to me or to members of my family from insurance companies or third party payers due to my treatment and hospitalization. I understand that I may receive a separate bill from the independently contracted providers for their services provided to me while I am a patient at HMHD. In consideration of the Districts cooperation in securing or attempting to secure said amount on my behalf, I release the facility, its agents, servants, employees and attorneys from all responsibilities and/or liabilities incidental to their release of my medical records and other information. I further authorize the District to release and/or send copies of my records, or portions thereof, to my referring providers and to providers on the staff of the facility or other facilities which were consulted in regard to my treatment, for their use in releasing information to third parties for the purpose of billing and collecting amounts due to them for services rendered. I further agree, whether I act as an agent for the patient or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the facility and/or treating, diagnosing or prescribing provider in accordance with the regular rates and terms of the District. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and costs.

4.2 I understand that the facility may need to review the care and treatment rendered to me during the course of my hospitalization. I consent and authorize any health care provider to provide to the District or its designee, including the quality improvement or risk management coordinator, information concerning my condition, care, treatment, and any event or occurrence while a patient in HMHD. This consent and authorization for release of information can be terminated by me in writing at any time. A photocopy of this release and authorization shall be sufficient authorization for any reason to respond to a request from the District or its designee for information concerning the subject of this authorization

4.3 I authorize and consent to the making or use of recordings, films, or other images of me including, but not limited to, photographs, videos, video recording/monitoring, electronic recordings or audio recordings. I understand that these images or recordings will be used for identification, diagnosis, and/or treatment in connection with the care provided to me by my attending provider(s), consultants, off-site health care providers who are involved in my care as part of telehealth and/or telemedicine services available to HMHD patients, and HMHD personnel. I understand that these images may be transmitted to off-site health care providers who are involved in my care as part of telehealth and/or telemedicine services offered at HMHD. I understand recordings, films or other images of me are considered protected health information (PHI) and further consent to the use of my PHI for internal educational, training, performance improvement and patient safety purposes at HMHD and/or by off-site health care providers with which HMHD contracts for patient care services. I am not consenting to

the use of recordings, films or other images of me for marketing or other external use(i.e. for release that is intended to be heard or seen by the public), and understand that a separate consent must be obtained from me before any such use occurs.

5. I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the provider or organization furnishing the services or authorize such physician or organization to submit a claim for Medicare for payment for me. I understand that I am responsible for any charges not covered by health insurance.

5.1 In the event I do not pay such charges when due, I agree to pay costs of collection, including attorney fees and interest. I authorize HMHD or its agents to access my credit report in order to collect any charges due. If I provide HMHD or its agents with my cell phone number, I authorize HMHD or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any email I provide is my personal email and I authorize HMHD or its agents to contact me via that email address.

For patients admitted Acute, SWB, placed in Observation or receiving outpatient treatment:

6. I do acknowledge and certify that I have read the general conditions of admission and that I am the patient or I am duly authorized to execute this acknowledgement on behalf of the patient. I accept the terms thereof this agreement. If I should leave the facility without the written consent of my attending provider, I hereby relieve said provider and the District of all responsibility for any action.

7. I have received the visitation rights policy.

8. I have received the packet with rights and responsibilities, including the visitation rights policy.