

Name: <b>Patient_Name</b>	Admission Date: <b>Admission_DateTime</b>	<b>SMITH Northview Hospital</b>
DOB: <b>DOB</b>	Attending Physician: <b>Physician</b>	
Episode#: <b>MRN</b>		

## PATIENT CONSENT FORM

In consideration of hospital and medical services to be rendered to me ("Patient") at Smith Northview Hospital (SNH), Patient, or the undersigned representative acting on behalf of Patient, does hereby agree and consent as follows:

### 1. CONSENT AND TREATMENT AUTHORIZATION

Patient does hereby consent to the rendering of hospital care and medical treatment, which may include diagnostic testing procedures and such medical treatment and care as considered to be necessary or appropriate by the Attending Practitioner, a member of the medical staff of SNH who has requested the care and treatment of Patient, and other enjoying staff privileges at SNH. Patient hereby authorizes the Attending Practitioner, the medical staff, and SNH to furnish and provide such treatment, surgical procedures, anesthesia services, X-ray examinations and treatments, drugs, supplies and other applications as may be ordered or requested by Attending Practitioner and those acting in his or her place.

This consent to receive medical treatment includes, but is not limited to, examinations (X-ray or otherwise), laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedures and medical treatment, and other services which Patient may require.

In the event that SNH should determine that blood specimens should be provided by Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent for blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed appropriate for the safety of others.

This consent shall be valid until the patient revokes this consent in writing or until treatment is completed.

### 2. RISK AND DISCLAIMER OF GUARANTEES

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of adverse results and injury. Patient hereby acknowledges that no guarantees have been made to Patient as to the results of procedures which Patient may undergo while at SNH.

### 3. ACKNOWLEDGEMENT BY PATIENT

Patient understands that: (a) It is a customary, absent emergency or extraordinary circumstances, that no substantial medical procedures be performed upon a Patient unless and until he/she has had the opportunity to discuss these procedures with the Attending Practitioner or other health professionals so that the Patient may be informed of the contemplated procedures, (b) Each Patient has the right to consent, or to refuse consent, to any proposed procedures or therapeutic course of treatment, (c) Patient understands that events may occur at SNH which make it necessary and imperative that medical treatment be provided on an emergency basis and without opportunity for discussion with Patient or with Patient's representative. Patient does hereby consent to emergency treatment if and when the same is deemed necessary and appropriate by Attending Practitioner or other medical personnel at SNH.

### 4. STATUS OF PRACTITIONERS

Patient understands that the practitioners and others enjoying staff privileges at SNH, including Attending Practitioner, may not be employees or agents of SNH, but, rather, are independent contractors who have been granted practice privileges for the care and treatment of Patients at SNH. These independent contractors exercise their independent medical judgment and discretion, for which SNH is not responsible.

### 5. TEACHING ACTIVITIES

Patient recognizes that among those who may attend Patient at SNH are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in Patient care activities as part of their medical education.

### 6. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Authorization is hereby granted to SNH by Patient, or the undersigned representative acting on behalf of Patient to release to Patient's primary care physician or partner(s) accepting patient on transfer and/or Patient's insurance company or other companies, their agents, or other third party payers, confidential or other information concerning the diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient or any minor children (including copies of records) as may be requested or necessary for the completion of claim processing relating to Patient's hospital bills. This authorization shall include information about drug/alcohol/chemical addiction or treatment, psychiatric conditions, AIDS, HIV and other privileged information.

### 7. ASSIGNMENT OF BENEFITS

I hereby assign my benefits to SNH for services provided to me by SNH. I hereby certify that the insurance information I have provided is true and accurate and I have provided proof of all health insurance effective as of the date of service below. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company.

I hereby authorize SNH to submit claims, on my behalf, to the insurance company listed on the copy of my current insurance card or insurance information I have provided in good faith.

I hereby instruct and direct my insurance company to pay my healthcare benefits directly to SNH. If my current policy prohibits direct payment to the provider of service, I hereby further instruct and direct my insurance company to make the check payable to me, but mail it directly to SNH for the professional or medical expense benefits allowable, which would otherwise be payable to me under my current insurance policy, as payment towards the total charges for the services rendered.

This is a direct and express assignment of all my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said facility and professional service charges over and above the insurance payment. Upon receipt of said check, I authorize SNH to endorse and deposit checks received on my account, on my behalf, even when written as payable to me.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or other related payer, including an employer health plan, as well as to my attorney in the event of their involvement in this case. I authorize SNH to be my personal representative, which allows it to: (1) submit any and all appeals when my insurance company denies benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company including but not limited to accident details or other coverage information, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits.

I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay proper benefits within 90 days of any and all appeals or requests for information.

**8. RELEASE FROM RESPONSIBILITY FOR PERSONAL VALUABLES**

Patient understands that SNH shall not be liable for the loss or damage of any personal belongings, including but not limited to money, jewelry, hearing aids, eye glasses, dentures and other items of value.

**9. PATIENT'S CERTIFICATION**

Patient, or the undersigned representative authorized to act on Patient's behalf, hereby certifies that this form has been understood and read and that satisfactory explanations have been given for any questions asked. IF this form is signed by Patient's representative, then such representative hereby certifies that he/she has the legal rights to consent for the Patient, and agrees to indemnify (hold harmless) SNH from any liability to Patient arising from such representative's actions in signing this form on Patient's behalf.

**10. PHYSICIAN OWNERSHIP/INVESTMENT**

In accordance with CMS disclosure provisions of ruling 42 C.F.R. 489.3 and in order to assist our patients in making informed decisions regarding their care; we are furnishing you this written notice at the beginning of your hospital stay or outpatient visit that some physicians have an ownership or investment interest in this hospital. A list of physician owners or investors is available upon written request to the Compliance Officer of Smith Northview Hospital.

**11. ORGAN/TISSUE DONATION**

The patient understands that he/she has the right to donate any organ or tissues for transplantation and that he/she may do so by completing an Anatomical Gift Form.

**12. WEAPONS, EXPLOSIVES, DRUGS**

Patient understands and agrees that if SNH at any time believes there may be a weapon, explosive device(s), any type of illegal substance or drug, or any alcoholic beverage in my room or in my belongings, then the Hospital may search my room and belongings, confiscate any of the above listed items found, and dispose of them as appropriate which may include delivery of items to law enforcement.

**13. DANGER OF SMOKING**

In an effort to improve patient health and promote a healthy life style, the physicians and staff at SNH are giving information to all patients on the danger of smoking and ways to quit smoking. Please share this information with your loved ones about the proven risks of second hand smoke. By signing this consent form, I acknowledge that I have received this educational material.

**14. CONFIDENTIALITY**

Patient hereby acknowledges receipt of the Patient Rights and Responsibilities and Notice of Privacy Practices by signing below. Patient further agrees to notify SNH upon signing below if he/she prefers not to be listed in the Hospital Directory (which includes name, room number and general condition to anyone who inquires). By opting out no information will be divulged whatsoever to any person concerning the Patient's presence at the Hospital.

**15. VALIDITY OF FORM**

Patient hereby authorizes that a copy of this document may be used in place of and is as valid as the original.

**16. ADVANCE DIRECTIVES**

Federal law mandates that patients be provided information concerning their right to make advance health care decisions. If you already have a Living Will or Durable Power of Attorney for Health Care please make your doctor and the hospital aware of your wishes. A copy of this information must be provided to the hospital immediately. An advance directive is not required to be treated.

**Yes, I have executed an Advance Directive. I will provide a copy to the hospital immediately.**

**No, I have not executed an Advance Directive.**

Do you want to be included in Hospital Directory?

**Yes**    **No**

<b>Date</b>	<b>Date</b>
<b>Patient Signature</b>	<b>Patient Signature</b>
<b>Witness Signature</b>	<b>Witness Signature</b>