Hendricks Regional Health

# AUTHORIZATION FOR TREATMENT AND PATIENT FINANCIAL RESPONSIBILITY



1. **MEDICAL AND SURGICAL CONSENT:** I request and authorize my provider(s) and other provider(s) who may attend me during this Emergency Services Department visit, Ambulatory Care Services visit or Hospitalization (hereinafter all referred to as "Medical Treatment"), their associates, assistants, and Hendricks Regional Health, its agents, employees, and students of affiliated health care training and/or education programs, (hereinafter referred to as the "Hospital"), to provide and perform such medical and surgical care, tests, drugs, procedures, other services and supplies as are considered advisable for my health and well-being. This may include sedation/anesthesia, pathology, radiology, tests, emergency services, other special services consultations, virtual consultations and sharing my medical records with these onsite and virtual consultants. I also consent to the administration of sedation/anesthesia, as medically indicated, by a qualified provider or person operating under the supervision of a qualified provider. The administration of sedation/anesthesia may involve certain risks including reactions to medications, which could, on rare occasions, result in death. May also involve dental risks including chipped teeth or dislodgement. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to or relied upon by me. I authorize Hendricks Regional Health to dispose of any tissues or parts in accordance with its customary practice. For procedures such as surgery that are planned (not urgent or emergent), I will have the chance to review the risks and benefits with my provider before giving consent. In urgent or emergent situations, I understand that it may not be possible to have a full and complete discussion prior to the procedure. In the unlikely event that a Hospital employee, member of the medical staff, or contracted worker or student is accidentally or intentionally exposed to my blood or other potentially infectious body fluids, I consent to testing for bloodborne diseases. These diseases include, but are not limited to, hepatitis and human immunodeficiency virus (HIV, the virus that causes AIDS). I understand that the results of these tests will become a permanent part of my confidential record and will be utilized in counseling the exposed individual regarding his/her risk of developing a disease after the exposure. I will not be charged for these tests if related to an accidental or unintentional exposure.

2a. **RELEASE OF INFORMATION/JOINT NOTICE OF PRIVACY PRACTICES:** I further request and authorize the Hospital, its Providers, all Independent Contracting Providers and Providers Groups (hereinafter all referred to as "Medical Care Providers"), to release to my insurance carrier or third-party payers a copy of my medical records in connection with Workmen's Compensation, to release my medical records to others responsible for insurance claims and investigations. I further certify that the information given by me if applying for payment under Title XVIII (Medicare) and/or Title XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. Upon this visit or admission, the Hospital will provide via telephone at information center, my name, room number, telephone number, and condition. I hereby release all Medical Care Providers from all legal liability that may arise from the release of such information. I permit a copy of this authorization to be used in place of the original. I was offered a copy of the HRH Joint Notice of Privacy Practices.

I understand I have the right to request my electronic health information be electronically transmitted to another person or organization, subject to certain exceptions. I understand that information that has been transmitted in this fashion to another person or organization at my request is no longer under Hendricks Regional Health protection and control, not subject to Hendricks Regional Health Privacy Practices and potentially not subject to the same confidentiality security, or privacy laws applicable to Hendricks Regional Health. I assume all liability for the consequences of requesting the electronic transmission of my health information. I agree that I am responsible to confirm any confidentiality, security or privacy protections with the person or organization to whom I am requesting my health information be sent, which should be addressed prior to requesting such transfer.

Hendricks Regional Health associates understand and agree that associate health records are part of his/her medical records in Epic and available to his/her treating providers.

2b. **AUTHORIZATION TO RELEASE INFORMATION FOR UTILIZATION REVIEW PURPOSES:** I authorize the Hospital to release information during and/or post-Hospitalization when necessary or requested to my insurance carrier or their authorized agent.

2c. **PATIENT ASSIGNMENT BOARD:** I authorize the Hospital to display in public view my name, room number and provider, for purposes of room and staff assignments.

3a. **AUTHORIZATION FOR USE OF SIDERAILS FOR ACCESS TO PATIENT SERVICES:** I authorize the Hospital to use one or two upper bed side rails so I may have access to needed patient services i.e., nurse call light, television & light controls, telephone, and bed adjustment controls.

3b. **AUTHORIZATION FOR USE OF RESTRAINTS:** I authorize the Hospital to utilize restraints, if needed to protect myself and others from harm.

4. **PERSONAL VALUABLES:** Money, jewelry and other similar valuables may be deposited for safekeeping. Articles of clothing, blankets, purse, or other personal property brought with me but not required in the Hospital should be taken home. I acknowledge that money, jewelry (watches, rings, bracelets, etc.), and similar property (such as eyeglasses, hearing aids, and dentures), unless deposited for safekeeping, and all other personal property including but not limited to clothing, blankets, radios, and purse are kept at my own risk, and the Hospital is not liable in the event of loss, or damage. NO HOSPITAL EMPLOYEE HAS THE AUTHORITY TO WAIVE THIS RULE.

5. **AUTHORIZATION TO RECEIVE TELEPHONE AND OTHER ELECTRONIC COMMUNICATIONS:** I authorize the Hospital, the Hospital's affiliates and subsidiaries and the Hospital's agents, along with any billing services, collections agencies, attorneys or other agents who may work on their behalf, to contact me on my residential and /or wireless telephone using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, or other computer assisted technology, or by text message, electronic mail, or any other form of electronic communication.

**I consent to treatment for this admission or for repeat treatments from _____through _____ or _____number of treatments.**

6. **ASSIGNMENT OF PAYMENT AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY.** I hereby assign payment otherwise payable to me from Medicare, Medicaid, insurance carriers, employee health benefit plans and other third-party payers (collectively referred to as "Plans") to the Hospital and other health care providers who provide services, care, or treatment to me at the Hospital.

   I acknowledge that I am responsible for knowing the limitations of my Plan benefits and agree to be responsible for paying the charges billed for services, care, or treatment that my Plan deems to be: (i) not a covered benefit; (ii) in excess of the Plan's benefit limitation or (iii) not medically necessary, investigational or experimental.

   The Hospital will make a reasonable effort to verify my Plan's coverage for the services, care, and treatment I expect to receive at the Hospital and to notify me, in advance, of items it knows are not covered benefits. However, should my Plan ultimately deny payment for the services, care and treatment provided to me, I agree to promptly pay, when requested by the Hospital, the difference between the Hospital's billed charges for the services, care, and treatment I received and the amount paid by my Plan, other than those amounts excluded by a written agreement signed by an authorized Hospital representative and/or the Hospital's patient financial assistance policies. Upon request, an authorized Hospital representative will be made available to explain eligibility for financial assistance from the Hospital.

   If the Hospital refers my account for collection, I will be responsible for paying the cost of collection, including reasonable attorney fees, expenses, and interest as allowed by Indiana law.

7. **INDIVIDUALS WHO CAN CONSENT FOR TREATMENT OF PEDIATRIC PATIENT(S):** I, the undersigned parent or legal guardian of the patient named above further authorize that the individual(s) named below may also consent to treatment at future visits if I am unavailable. I have the right to revoke this approval at any time by communicating this decision in writing. Any person not included on this list will not be authorized to consent treatment. **Stepparents must be listed below in order for provider to provide treatment. If you have a teen that will be driving themselves, please indicate their name below. If you are the mother or father signing this authorization, please list other parent's name below.**

_____ _____

Signature Authorized Representative Date/Time Patient Signature Date/Time

_____ _____

Relationship To Patient Witness

_____ Patient's Date of Birth ____/____/____

Insurance Reason Patient Unable To Sign Subscriber's Date of Birth ____/____/____

PROVIDER OFFICES: Further authorized individuals who may also consent to treatment at future visits:

_____ _____

Relationship to Patient Witness

_____ _____

Relationship to Patient Witness

_____ _____

Relationship to Patient Witness

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