

UPSH
Consent to Hospital and Medical Treatment

Patient sticker

1. CONSENT TO TREATMENT: I (or my representative) voluntarily consent to my hospital care as a patient at UPSH and consent to and authorize the administration and performance of all medical treatment and procedures, the use and administration of any pharmaceutical products including contrast media, therapeutic agents, anesthesia and/or anesthetic agents and the use of any medically accepted diagnostic procedures that may be prescribed and deemed appropriate and necessary by my attending physician or associates or assistants of his/her choice.

I further authorize the personnel of UPSH to take samples, specimens and cultures, perform medically necessary laboratory and diagnostic tests and procedures and to dispose of such in the customary fashion, and to take such precautions as may be necessary for my treatment and safety and safety of others. I consent to be tested for human immunodeficiency virus infection (AIDS), hepatitis, or any other blood-borne infectious disease if a doctor orders the test for diagnostic purposes for me or in the event a healthcare worker has been exposed to my blood or bodily fluids.

I also consent to have photographs or videotapes taken as may be requested by my physician.

I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the outcome of the medical or surgical treatment or examination to be rendered at UPSH. I understand that there may be some risks from radiation (x-rays) and some medicines if I am pregnant. I know that it is my responsibility to discuss possible pregnancy with my physician and to advise the technician before an exam.

I understand that the physicians who render professional services to me at UPSH are independent practitioners and are not employees or agents of UPSH. UPSH is not responsible for the acts or omissions of physicians who are not directed or controlled by UPSH. I further understand that I will be billed by the individual physician for services rendered to me by these physicians.

I understand that if I leave the hospital against the advice of my physician or refuse treatment or medication that UPSH is not responsible for any ill effect my decision may cause me. I understand that I may revoke my consent at any time and that this decision is mine alone. This consent shall remain in full force and effect until revoked in writing.

X Patient/Legal Rep. Initials _____

2. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at UPSH.

Patient or patient’s legal representative: Check appropriate box and sign

- I have received a copy of the notice of privacy practices
- I have previously received a copy of the Notice of Privacy Practices
- I do not want a copy of the Notice of Privacy Practices

X _____
 PATIENT/LEGAL REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

For UPSH staff use only if patient/legal representative has not acknowledged above. Check appropriate box and sign.

- Patient or legal representative refused to sign Acknowledgement
- Patient or legal representative unable to sign Acknowledgement
- Patient or legal representative previously acknowledged Notice of Privacy Practices

UPSH EMPLOYEE SIGNATURE

DATE

3. ADVANCE DIRECTIVE QUESTIONS: (Surgical Hospital Only - Completed by Patient Registration)

Does the patient have an advance directive? _____yes _____no _____Unable to determine

If yes, Check applicable advance directive(s)

_____Living Will, _____Durable Power of Attorney for Healthcare, _____DNR Comfort Care (DNRCC), _____DNR Comfort Care Arrest (DNRCCA)

If yes, Advance Directive copy here? _____yes (Place in medical record)

If no, Would the patient/family like information? _____yes, Packet given to :_____

_____no, packet refused by:_____

5. .FINANCIAL AGREEMENT

Financial Responsibility: I agree to pay the hospital any actual or estimated co-payment or co-insurance as pertains to treatment received in the course of my stay in the hospital. I agree that I am financially responsible to the hospital and/or physician(s) for services not covered by medical insurance (private or state provided), and agree to pay any charges not covered by insurance. I understand that I am entitled, upon request, to a list of usual and customary charges for room and board as well as a selected number of clinical services.

Assignment of Benefits: I hereby assign and transfer to the hospital all rights I may have to Medicare and/or physician services rendered, and authorize any insurance company or third party payments to be made directly to the hospital and/or physician(s) for services rendered.

Release of Information: I hereby authorize the hospital to permit access to and to release medical information and/or copies of Medical Records to the Social Security Administration or other authorized governmental agency, insurance companies or associations and self-insured organizations, as required for the purpose of establishing or verifying my eligibility for benefits for hospital or physician claims for services rendered to obtain reimbursement from any such third party payors. I specifically authorize the release of information concerning treatment to HIV testing, AIDS or AIDS related condition, treatment of psychiatric condition(s), and/or treatment of alcoholism or drug abuse. This consent will expire 6 months after the date of discharge. I am aware that I can revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

Personal Valuables: I acknowledge that personal valuables such as money and jewelry should not be brought to the hospital. I hereby release the hospital from any responsibility for valuables, money, personal or other possessions that are not secured within the hospital depository. Patients are strongly encouraged to send all valuables home with a family member.

Witness

X_____
Signature of Patient

Date/Time AM / PM

If the patient is unable to consent or is a minor (under 18)

Witness

Closest Relative or Legal Guardian/Representative

Date/Time AM / PM

Relationship to Patient