HSHS St. John's Hospital

# GENERAL CONSENT FOR MEDICAL/SURGICAL CARE

**IN ORDER TO PREVENT ANY MISUNDERSTANDINGS, THE HOSPITAL REQUIRES THE FOLLOWING TO BE SIGNED FOR ALL PATIENTS.**

## I. MEDICAL CARE / SURGICAL CARE

**A.** **Treatment**: I understand I am suffering from a condition requiring diagnostic, medical and/or surgical treatment and do hereby consent to such diagnostic procedures and treatments to be accorded either as a hospital inpatient or outpatient. I further consent to such diagnostic, medical and/or surgical treatments (including x−ray) performed or ordered by my attending physician(s), his assistants or designees as is necessary in the judgement of my attending physician(s). Further testing and procedures may be performed on specimens received as deemed necessary by my physician or according to hospital procedures.

**B.** **Medical Observers / Health Care Providers**: I understand that HSHS St. John's Hospital is a private, Catholic hospital, and is affiliated with the SIU School of Medicine and that Residents, Fellows and medical students may assist in providing my care and that my medical records may be used for purposes of research, education and patient care by these individuals. I also understand that HSHS St. John's Hospital has its own training programs (i.e., nurses, other allied health professionals) and observational experiences, and also understand they may assist in or observe the provision of my care and the completion of my medical records. I acknowledge and consent to designated observers being present, unless I have requested otherwise. Designated observers may include students or industry representatives that are present to provide technical support to physicians using specific instruments or devices. Video monitoring may be intermittently used for patient care and security purposes

**C.** **Specimens/Tissues**: I hereby authorize HSHS St. John's Hospital to either retain, preserve, and/or use for scientific or teaching purposes, or to dispose of at their convenience in an approved manner, any specimens or tissues taken from my body during my hospital treatment.

**D.** **Administration of Blood:** I hereby consent to the administration of blood or blood components upon order of my attending physician(s). I understand this consent involves a risk of contracting viral hepatitis, AIDS, or other reaction, and agree that no assurance against hepatitis, A.I.D.S., or other adverse reaction has been given by the hospital, its employees, its Transfusion Service or any person whatsoever as to blood or blood components as administered.

**E.** **Health Care Decision/Patient Rights**: I acknowledge receiving written information reflecting hospital policies regarding my rights as a hospital patient, and my rights to be a participant in, and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives, and to provide the hospital with any such directives for my physicians and health care providers to be aware of and rely on. I have been referred to the Notice of Privacy Practices for a more detailed description of the uses and disclosures of my protected health information, and I understand I have a right to review the Notice prior to signing this consent.

## II. VALUABLES AND RECORDS

**A.** **Valuables:** I understand that the hospital maintains a safe for the safekeeping of any valuables (i.e., money, jewelry, and/or other articles of value which I possess), and I fully understand if I choose not to accept the hospital safekeeping services, that the hospital will not be liable for loss or damage to any of my personal valuables while I am receiving treatment in the hospital.

**B.** **Release of Information**: I authorize HSHS St. John's Hospital to release and/or send to any insurance company or payor, its agents, servants, or employees, and attorneys, all medical information compiled by HSHS St. John's Hospital or received from another health care facility/agency or physician, which may also include mental health, drug and alcohol abuse, HIV and AIDS. I understand this authorization is furnished to enable HSHS St. John's Hospital on behalf of itself, the physicians for whom HSHS St. John's Hospital is authorized to bill, my treating physician (and physician extenders), and myself to obtain, or attempt to obtain, proceeds, benefits, or amounts due to me or members of my family from insurance companies due to my hospital treatment while in the hospital. In consideration of HSHS St. John's cooperation in securing or attempting to secure, said amounts for me, I release HSHS St. John's Hospital, its agents, servants and employees from all responsibilities and/or liabilities incident to their release of my records or other appropriate information. I authorize HSHS St. John's Hospital to release and/or send copies of pertinent portions of my medical record to my referring physician(s) and to physician(s) who may be involved in my future care. I further authorize the release of information and portions of my medical record compiled by HSHS St. John's Hospital or received from another health care facility/agency or physician to institutions or agencies in connection with the discharge planning process as deemed appropriate by my attending physician or hospital personnel, as well as to individuals or agencies involved in assessment of the quality of care or services.

**C.** **Health Information Exchange:** I understand that my medical records will be exchanged among my health care providers through a Health Information Exchange (HIE). I authorize HSHS St. John's Hospital to share my information with the HIE, including sensitive information, for all individuals and entities who are authroized to access such information for purposes related to my treatment. Sensitive information includes: HIV/AIDS, mental health records, drug and alcohol treatment, genetic test results, and sexual transmitted diseases. I understand that:

- I may request to Opt−Out of HIE and continue to receive care;
- If I have a positive diagnosis of HIV, I have the opportunity to request that my information will not be provided to the HIE by means of Opt−Out;
- If I Opt−Out my providers will not have the most up to date information about my care even in cases of medical emergency;
- That my Opt−Out selection will remain in effect until I change it in writing. I understand that any information that is disclosed before I submit this Opt−Out cannot be taken back and will remain in the HIE.

I understand that if I would like to Opt−Out I need to make the request in writing. I may do so with the Registration Department, Health Information Department or the Privacy Officer.

**D. Protected Health Information:** I understand protected health information may be used and disclosed to carry out treatment, payment or health care operations.

**E. Authorization to Photograph/Videotape:** I understand that photographs, videotapes, recordings, digital or other images may be recorded to document my care. I understand that the Hospital will retain the ownership rights to these images, but that I will be allowed to access/listen to them or obtain copies whenever possible. Images that identify me will be released and/or used outside the organization only upon written authorization from me or my legal representative or as allowed by law.

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**III. FINANCIAL AGREEMENT**

A. **Patient Medicare Certification:** I certify that all information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct, and I authorize release of any of this information needed to act on this request. I further request that payment of authorized benefits be made in my behalf. I further assign payment for the unpaid charges to the physician(s) for whom HSHS St. John's Hospital is authorized to bill in connection with its statement. I further understand I am personally responsible for for any health insurance deductibles, co−insurance, and any charges not paid for by Medicare.

B. **Insurance Requirements:** I understand that my insurance company may have placed restrictions on my insurance coverage, services, facility and/or provider which must be satisfied prior to admission or treatment. These restrictions could include pre−admission screens, second opinion surgery, pre−admission certification, designated facilities and/or other requirements. Restrictions may also be placed on physicians that provide services or render care during my stay (i.e. anesthesiologist, pathologist, radiologist). (While the insurance company has made it the patient's responsibility to fulfill these requirements, HSHS St. John's Hospital wants to be certain that you are aware of this). I understand that not fulfilling all insurance requirements prior to receiving care could result in the reduction of benefits or coverage. In the absence of fulfilling these requirements or in the case of a pre−admission denial, the patient is responsible for payment of appropriate charges for services delivered.

C. **Authorization to Pay Insurance Benefits**: I hereby assign, transfer and set over to the following parties all of my rights, title, and interest to Medical Reimbursement Benefits (Basic and Major Medical) under the insurance policies listed on my admission form in an sufficient to pay my indebtedness to:

1. HSHS St. John's Hospital
2. Hospital−based physicians and physicians for whom HSHS St. John's Hospital is authorized to bill.
3. Treating physicians/physician extenders, including hospital based physicians and physicians for whom HSHS St. John's Hospital is not authorized to bill.

D. **Self−Pay Balances:** I understand I am financially responsible for charges not covered in full or in part by the authorizations in Section III C. Should the amount be referred to any attorney or collection agency for collection, I shall pay all reasonable attorney's fees, court costs, and/or collection expense. I hereby consent to receiving auto−dialed and/or pre−recorded message calls to my cellular telephone and to any telephone number provided by me at time of registration from HSHS St. John's Hospital or its affiliates and their agents including without limitation, any account management companies and independent contractors including without limitation, any debt collectors. IT IS FURTHER AGREED that any credit balance resulting from payment of the insurance or other sources may be applied on any other account owed by the insured or his/her family.

**E. Emergency Room Charging Procedure:** I understand I am financially responsible for all tests and/or services provided to me while both in the emergency room waiting area, emergency room south, or the emergency department. If I leave before my care is complete, I understand I am still financially responsible for all tests performed and/or services to me.

I understand that all physicians, physician assistants, and Advanced Practice Nurses (APNs) providing my care including, but not limited to, my treating physician, hospital−based physicians, radiologists, pathologist, anesthesiologists, neonatologists, and Emergency Department physicians are not employees or agents of the hospital, but rather are independent contractors who have been granted the privilege of using its facilities for the care and treatment of patients.

I AGREE TO ALL OF THE AFORESAID WITH THE EXCEPTION OF: _____

**AND CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACKNOWLEDGE RECEIPT OF HSHS ST. JOHN'S HOSPITAL'S NOTICE OF PRIVACY PRACTICES (NPP)**

_____
Witness signature

_____ _____
Date Time

For Office use only:
❑ Patient Previously received a copy of the NPP
❑ Unable to provide NPP or obtain acknowledgement

_____
Signature of patient/policy holder

_____
Signature of closest relative (indicate relationship) or legal guardian
If patient is unable to sign or is a minor

_____
Signature of policy holder if different from patient

_____
Reason patient is unable to sign