Sacred Heart
HOSPITAL
EAU CLAIRE, WISCONSIN
AN AFFILIATE OF HOSPITAL SISTERS HEALTH SYSTEM

REQUEST FOR MEDICAL CARE

Patient Name:_____ _____ _____
(Last) (First) (Middle) (Social Security #) (Date of Birth)

I. Medical Care Request and Authorization

I understand that I may have a condition that requires medical care. I am requesting and authorizing medical care by Sacred Heart Hospital, any of the physicians associated with Sacred Heart Hospital, and other health professionals who are associated either with Sacred Heart Hospital or the facility at which the medical care is rendered whom Sacred Heart Hospital considers reasonably necessary for my care. I agree to their participation in my care.

I am aware that medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of my medical care.

I understand that unforeseen conditions may arise during the rendering of my medical care and I hereby authorize Sacred Heart Hospital and its designees to perform any other procedures they deem appropriate in the exercise of their professional judgment to address such conditions.

I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advance directives, and to provide any such directive for my physicians and health care providers to be aware of and to rely on.

I understand that I may revoke this request and authorization for medical care at any time by written notice to Sacred Heart Hospital.

II. Release of Medical Information Consent

I consent to the development, use and disclosure of medical information about me as noted in the next paragraph.

Sacred Heart Hospital and any person or entity designated by it may develop, use and disclose medical information about me (i) for my treatment and to other physicians, health professionals or entities who may be involved in my care; (ii) to obtain payment for treatment by billing and performing any other functions necessary to obtain reimbursement for care delivered to me, including collections of such payments from me by collection agencies or attorneys; and (iii) to support Sacred Heart Hospital's health care operations such as analyzing, monitoring, and comparing patient data to improve treatment methods and for corporate compliance functions. In addition, Sacred Heart Hospital may use or disclose medical information about me for research studies, funeral arrangements, organ and tissue donation, workers' compensation, emergencies and all uses and disclosures that are permitted or required by the laws of the State of Wisconsin or federal laws without my consent.

This consent permits disclosure of information and reports in my file, including HIV information and HIV test results, if any.

III. Notice of Privacy Practices Acknowledgement

HIPAA (Health Insurance Portability and Accountability Act) is a federally mandated law. It provides guidelines to health care providers about the privacy of my medical information and requires Sacred Heart Hospital to inform me of its privacy policies.

I acknowledge that I have received a copy of the Sacred Heart Hospital's Notice of Privacy Practices. It describes how my medical information may be used within Sacred Heart Hospital, how it can be disclosed outside of Sacred Heart Hospital, how I may access my medical information and my rights with regard to my medical information. Sacred Heart Hospital reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may request a copy of a current Notice of Privacy Practices at any time.

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IV. Patient Rights & Responsibilities Acknowledgement

I acknowledge that I have received a copy of the Patient Rights & Responsibilities Brochure. Sacred Heart Hospital reserves the right to change the rights and responsibilities that are described in the Patient Rights & Responsibilities Brochure. I may request a copy of a current Rights & Responsibilities Brochure at any time.

V. Financial Agreement

I understand that I am personally responsible for charges incurred for medical care rendered by Sacred Heart Hospital. I understand that Medicare, insurance companies, my employer and other payors may have restrictions on reimbursement for medical care rendered by Sacred Heart Hospital. These restrictions may include pre-certification, use of designated facilities, frequency of tests performed, non-covered services, deductibles, co-payments, and other requirements. I understand that it is my responsibility to comply with such restrictions and that I will be personally responsible for any charges not reimbursed by other payors.

I certify that all information given by me in applying for payment by Medicare, if applicable, is correct. I understand it is mandatory to notify Sacred Heart Hospital of any other party who may be responsible for reimbursement of my medical care. (Section 1128B of the Social Security Act and 3 I U.S.C. 3801-3812 provides penalties for withholding this information.) I certify that all information given by me to bill Medicare, insurance companies, my employer and other payors is correct and complete. I understand that payors may have time limits for filing claims and providing incorrect and/or incomplete information may result in denial of reimbursement for which I will be personally responsible.

I agree that any credit balances resulting from payments by insurance companies, employers, myself and others may be applied against any other balance due by me or family members.

I authorize all payments for medical care rendered to me by Sacred Heart Hospital to be assigned, transferred, and paid directly to Sacred Heart Hospital. I will remit to Sacred Heart Hospital immediately the full amount of any payment that may be received by me, a family member or custodian from Medicare, an insurance company, my employer, or any payor for medical care rendered to me by Sacred Heart Hospital. I hereby release Sacred Heart Hospital from any and all legal responsibilities or liabilities relating to my financial responsibilities.

VI. Disclosure of Health Information

In compliance with Sacred Heart Hospital privacy practices, you may designate individual(s) to whom Sacred Heart Hospital may disclose your protected health information. This may include individually identifiable information related to past, present, or future appointment, medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires separate written consent. I you do not wish to designate individual(s) to receive your protected health information, indicate “none” below.

I do hereby authorize Sacred Heart Hospital to disclose protected health information to the following:

_____ _____ _____

_____ _____ _____
Name Relationship to Patient Telephone Number

I acknowledge that I understand all of the above and agree to abide by the terms of this document. I understand that I have an option to revoke Disclosure of Health Information authorization at anytime.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed Name of Patient or Guardian Relationship to Patient