General Consent for Diagnosis and Treatment

- I consent to care, examination and treatment from Lovelace Health System (LHS) and it's medical staff, employees, independent contractors and employees of placement agencies. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of examinations, treatments or procedures performed by LHS and its providers.
- I understand that examination and treatment that I may receive in the LHS Emergency Department are provided on an emergent basis and are not intended to replace comprehensive and routine medical care.
- I accept all responsibility for my health and safety if for any reason I leave this LHS facility prior to being released by a health care provider.

Independent Status of Physicians, Residents, Medical Students and Nurses - CAUTION! Please Read Carefully Before Signing:

The medical treatment rendered during my hospital admission may be provided by physicians, residents, and medical students (under the supervision of physicians and/or residents). These physicians, residents, and medical students are independent contractors and not employees of the hospital. In addition, nursing care rendered during my hospital admission may be provided by nurses or other professional staff who are also independent contractors or employees of a placement agency and not employees of the hospital. By signing this document, I acknowledge that:

- I have received adequate notification of this relationship and that the hospital is released from liability and is not legally responsible for the acts or omissions of such individuals
- The hospital has not represented or taken any other action to induce me to believe that the physicians, residents, medical students and nurses are employees or agents of the hospital.
- I understand, I will recieve a separate bill from the provider.

General Duty Nursing

- I understand that LHS provides only general duty nursing care. Private duty nursing may be arranged directly between an agency and the patient at the patients expense.

Patient Initials:_____

Release Medical Information, Assignment of Benefits, Insurance Claims and Payment of Charges

I understand that LHS will use my information for the purposes of treatment, payment and health care operations.

I authorize LHS to and any physicians involved in my care to disclose all or any part of my medical record, including mental health and/or substance abuse treatment records, and/or infectious disease records including but not limited to blood-borne diseases to any organization or insurance company that may be liable or responsible
for payment of charges associated with my care and for all other purposes of benefit payment.
If my injury is work related, I authorize the hospital to release any information from my medical records to my employer and/or it's designee or any insurance company that provides insurance.
For any medical devices I may receive, I agree to the release of my social security number and other required information to the manufacturer and the Food and Drug Administration. I understand that this information may be used to locate me should there be an issue related to the medical device(s).

I understand that information in my medical record is confidential but may be disclosed for purposes of medical education and research, professional review activities or review activities related to the cost, frequency, and quality of patient services provided. Otherwise, my medical record information will not be disclosed without my consent or the consent of my legal representative, unless required by law or a court order.
I understand that state law requires the reporting of certain positive test results, such as hepatitis and the antibody for HIV/AIDS virus to the Health Department.
I understand that the costs of my medical treatment that are quoted to me prior to billing are estimates. Actual charges may be more or less, and additional charges such as consulting physician fees or costs of pharmacy, laboratory, and supplies may not be compiled prior to my discharge. All charges will appear on my monthly statement.
I authorize and irrevocably assign payment directly to LHS for the full amount of medical insurance benefits payable under the terms of my policy(s).
I understand that filing of an insurance claim does not discharge my responsibility for payment of the charges incurred.
I agree to pay the actual charges for my medical treatment, less the amount paid to LHS by third party payers, if any. LHS may obtain a credit report on me from a credit reporting agency.
Should the account be referred for collection, I shall pay the reasonable cost of collection including attorney's fees.

Medicare Patient's Certification:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program, its intermediaries or the Professional Standards Review Organization any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or group health plan, as my "authorized representative" (including as such term is used in 29 C.F.R. §§ 2560.503-1(b)(4), 2560.503-1(c)(1)): (1) the right and ability to act on my behalf in connection with any claim, right, cause in action, or appeal that I may have under such policy and/or plan? and (2) the right and ability to act on my behalf to pursue such claim, right, cause of action, or appeal, including any benefit claim or appeal of any adverse benefit determination, in connection with such policy of plan with respect to any medical or healthcare expenses (however described or denominated) incurred as a result of the services or supplies I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursements, and any other applicable remedies including, but not limited to, recovery of losses, equitable relief, penalties, fines, and any other relief provided for under the Employee Retirement Income Security Act (ERISA).

Personal Property Release

I understand that I am responsible for my own personal belongings that I bring to LHS and keep in my possession while I am in a patient care area I have been advised that the LHS Security Office provides a safe where my belongings and valuables can be placed for safekeeping until the time of my discharge.

Patient Initials: _____

Weapons/Explosives/Drugs:

I understand that if at any time LHS believes there may be a weapon, explosive device, illegal substance or drug, or alcoholic beverage in my room or with my belongings, the hospital may search my room and belongings.

These items may be confiscated and disposed of as determined to be appropriate to include delivery to law enforcement authorities.

TCPA Consent Disclosure

You expressly consent to allow Lovelace Health System, to contact you by use of an automated telephone dialing device and to leave automated or pre- recorded voice messages, send you text messages, short message services messages (SMS), or send you email messages regarding your treatment, notification of appointments, notification that certain medications or other products or services being provided to you are ready for pick up, communicate to you about your account, or communicate with you regarding the collection of any money that you may owe to Lovelace Health System related to treatment provide to you, your child, or person to whom you are a guardian. You agree that this prior express written consent shall also extend to any third party that is servicing your account on behalf of Lovelace Health System or attempting to collect any money due regarding your account on behalf of Lovelace Health System. This consent does not extend to telemarketing of future goods and services to you. Your express consent includes contact to the following telephone numbers and email addresses.

Electronic Prescribing

Our facility may participate in Electronic Prescribing and may be asking for your preferred pharmacy to submit any prescriptions necessary upon your discharge. To facilitate this process we will be submitting your phone number and address on file to your preferred pharmacy.

☐ I have received information about the ***Incident Management System Program and Patient Rights and Responsibilities***.

☐ I have read this document, I have had my questions answered to my satisfaction, and I understand and agree to the content of this document.

Signature:_____ Date:____ /____ /____
☐ Patient ☐ Legal representative_____

If patient is unable to sign, state reason:_____
☐ Interpreter used - Name:_____

Witness: _____ Date:____ /____/____ Time:___ :___