Lawrence Memorial Hospital

Authorizations/Agreements/Insurance Assignments

1. **Consent to Treatment:** I understand I am under the care and supervision of my attending physician or designees and it is the responsibility of Lawrence Memorial Hospital (LMH) and its staff to carry out the instructions of these physician(s) or other allied health professional(s). I consent to x-ray examinations, laboratory procedures, medical or surgical or office services rendered to me under the general and special instructions of these health providers or other authorized providers. I recognize that some physicians furnishing services to me, including, but not limited to radiologists or pathologists are independent contractors and not employees of the hospital and will bill separately for their services. I agree that any and all removed tissues, organs, or parts may be disposed of in accordance with accepted medical practice and may be used in a non-identifying manner for scientific, educational or research purposes. I understand and consent to the testing of blood, urine or gastric contents and other body fluids for alcohol or drug content when performed for medical purposes.
2. **Patient Rights:** LMH respects the rights of patients to make informed decisions regarding their treatment while a patient at the hospital/facility. A separate form entitled "Patient's Bill of Rights" lists information regarding those rights. These are posted throughout the hospital/facility and I acknowledge having been offered a copy.
3. **HIPAA Privacy Policy:** You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. My signature below acknowledges that I have been offered a notice of the privacy practices of Lawrence Memorial Hospital.
4. **Release of Information/Subsequent Medical Care Providers:** LMH submits medication data to an electronic prescription repository and may exchange data with the repository as part of patient care.
5. **Communication about Your Care:** Concerned family members or friends often ask questions about your care or your children's care. To protect your confidentiality, the physicians, nurses, and other LMH staff will not discuss your care with anyone besides you, unless we have your permission to do so. I give the LMH staff permission to discuss my protected health information with the below individuals. I understand I can make changes to this list at any time by notifying a staff member in writing:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

6. **Leaving Messages:** I authorize the LMH to leave a message on my:
   ___ Primary Phone (Number_____)
   ___ Secondary Phone (Number_____)
   ___ Other Phone (Number_____)

7. **LAB/RADIOLOGY TESTS:** When lab/radiology tests are ordered in the clinic, your results will be communicated by phone to you. During that phone call you may request a copy of your lab results to be mailed to you. Please indicate below if you authorize the mailing of your test results upon verbal request.

   ___YES I authorize my test results to be mailed upon my verbal requests

   ___ **NO** I will fill out a release EACH time to get my results.

8. **Blood Testing:** I consent to serology testing, including Hepatitis B, C and HIV, in the event that my blood and/or body fluids is suspected to have come in direct contact with any health care worker(s), to determine if my blood has contagious viruses. I understand that the information obtained from such tests will be disclosed only as necessary to adequately protect me, the health of my family, and the health of the health care personnel who are or may become involved in my care and treatment.

9. **Illegal or Dangerous Articles/Substances:** I acknowledge my understanding that the possession of illegal drugs, weapons, or other similar contraband are not allowed on Hospital premises by patients or visitors, and such substances will be confiscated and turned over to local law enforcement personnel.
10. **Photography for Non-Clinical Purposes:** Patient photography or videotaping is not permitted during any procedure or treatment unless specifically authorized by the care giver.
11. **Teaching Program:** LMH is a clinical training site for students, including resident physicians. I understand these students or resident physicians may provide care to me under the direction and supervision of my attending physician, his/her designees, or hospital employees, as appropriate to the type of student.
12. **Advance Directives:** I have a right to formulate Advance Directives (such as a Living Will or a Durable Power of Attorney for Health care) and LMH will provide further information or help in completing them at my request.
13. **Do Not Resuscitate (DNR) Directives for Outpatients:** It is understood that LMH staff will respond to and provide resuscitation treatments to all patients receiving Outpatient examinations/treatments. Specific physician order will be required to exempt Outpatients from resuscitation efforts. This order must be renewed for all subsequent visits.
14. **Insurance Companies:** We will provide medical information and any other billing information to your insurance companies as necessary to bill for and substantiate the service you received in order to obtain payment for services provided.
15. **Assignment of Benefits:** I hereby assign to LMH any medical benefits arising out of any policy of insurance insuring the patient to be applied to the charges for services rendered. I understand I am financially responsible to Lawrence Memorial Hospital for charges not covered by this agreement. I agree not to revoke this assignment without written notice to LMH and any such revocation attempted will not be effective without notice from the insurance company to LMH. A copy of this assignment shall be as valid as the original.
16. **Financial Agreement:** I authorize LMH to bill and collect for their professional services. I understand and agree that LMH is not responsible for collecting insurance or for resolving any disputed insurance or other third party payer claim and to pay LMH all costs and charges incurred in connection with the services provided. It is agreed that if full payment is not made by insurance or other third party payer, the patient/guardian assumes responsibility for all remaining charges. I understand that a $30.00 returned check fee will be assessed for checks returned for any reason. I understand that a $50.00 fee may be assessed for failure to notify the clinic one business day in advance that I will not be able to keep my appointment and for cancellations the same day of the appointment.
17. **Statement to Permit Payment of Hospital and Medical Insurance Benefits to Hospital and Physicians:** I certify that the information given to me in applying for payment under TITLE XVIII or TITLE XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request payment of authorized benefits to be made on my behalf.
18. **ALL MEDICAID TITLE XIX PATIENTS:** I am aware that some or all services rendered may be considered co-pay, spend down or non-emergent and therefore, not covered by Medicaid. In the event these services are considered non-covered, I agree to be personally and fully responsible for payment of services to the hospital and/or to those in-hospital physicians and specialists who do their own billing.
19. **Vaccinations:** I understand that vaccinations may be recommended by CMS (Medicare) and included as a part of my plan of care by my attending physician(s).

THE UNDERSIGNED CERTIFIES THAT HE/SHE READ THE FOREGOING AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR IS DULY AUTHORIZED BY THE PATIENT'S GENERAL AGENT.

_____ _____ _____

Print Patient Name | Date of Birth | Date

_____ _____

Patient Signature, Guardian, Agent or Representative | Relationship to patient

Revised 12/27/12, 06/11/2014, 10/21/14