



## **TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Record No.: \_\_\_\_\_ Admission Date: \_\_\_\_\_

Rooks County Health Center, including its acute care, swing bed unit, long term care unit, emergency department, outpatient surgery and outpatient departments is hereinafter referred to as "Hospital".

**1. CONSENT FOR TREATMENT:** I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by myself or my family and the Hospital shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

**2. CONSENT FOR NEWBORN TREATMENT:** I request, authorize, and empower my physician(s) to make any provision for medical and surgical care for my newborn baby/babies that may be deemed necessary or advisable by my physician(s).

**3. CONSENT FOR BLOOD/BODY FLUID TESTING:** In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the Hospital determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

**4. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS:** I agree that the Hospital may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

**5. AGREEMENT TO PAY FOR SERVICES:** I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms. However, I am aware that any patient arriving at the facility will have a medical screening examination performed regardless of the ability to pay.

**6. ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign my insurance benefits otherwise payable to me to be paid directly to the Hospital. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

**7. MEDICARE/MEDICAID BENEFITS:** I authorize the Hospital to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the Hospital for services furnished to me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Hospital. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by Rooks County Health Center and payment is not made by Medicaid, you may be held responsible for the charges if your services are not covered by Medicaid.

**8. PERSONAL VALUABLES/BELONGINGS:** I have elected/refused (circle one) to place valuables (i.e., money, jewelry, credit cards, or other articles of unusual value, etc.) into the Hospital's safekeeping during my period of hospitalization. Dentures, glasses, hearing aids, my garments and essential daily necessities are considered personal belongings. I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Hospital CANNOT AND WILL NOT accept responsibility for loss of any of my valuables/belongings, if they are lost or misplaced.

**9. DENTURES:** The Hospital provides denture cups for me if I require them. I will take precautions to be sure my dentures are properly kept and cared for and they will be kept in the denture cup at all times when I am not wearing/using them.

**10. NOTIFICATION TO PATIENTS:** Certain diseases and conditions, including cancer, are required by law to be reported. I understand that the Hospital will comply with this by submitting the necessary information on my condition and myself to a centralized registration point.

**11. CONTRABAND WEAPONS/DRUGS:** I agree that should the Hospital find contraband weapons and/or nonprescription drugs not sold over-the-counter within my possession, these items will be confiscated and the police will be contacted.

**12. TOBACCO USE:** I understand that Rooks County Health Center is tobacco free. I cannot smoke or use tobacco of any kind in my room or anywhere in the hospital or its premises.

**13. USE OF APPLIANCES:** I hereby agree that in using any and all electrical appliances in my room, not owned by or under the control of the Hospital while a patient in the Hospital, I do so at my own risk and hereby absolve the Hospital from any and all responsibility for injuries or property damage which may result from any use of said appliance.

**14. PROVIDER NON-DISCRIMINATION ACT:** I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

**15. MEDICARE/TRICARE PATIENTS ONLY:** (only for acute care) I have received a copy of "An Important Message from Medicare/Tricare" and understand my rights as described in that document.

**16. PATIENT RIGHTS INFORMATION:** I have reviewed/received a copy of "Patient Rights and Responsibilities" and understand my rights as described in that document.

**17. NOTICE:** Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

**18. ADVANCE DIRECTIVE INFORMATION:** (Complete this section for acute, ambulatory surgery, observation and swingbed/respice patients only.)

	YES	NO
Do you have a living will?		
Do you have a Medical Durable Power of Attorney (DPOA)?		
If yes, is the living will or DPOA on file?		
If no, were you given Advanced Directive Education Material?		

**PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING**

**19. CONSENT TO DISCLOSE GENERAL INFORMATION:** I understand that my name, location in hospital, and general condition may be provided to any person asking about me by name, and to members of the clergy, my family, individuals involved in my health care, for disaster relief efforts, or as required by law. I do \_\_\_\_\_ do not \_\_\_\_\_ give consent for this information to be disclosed.

\_\_\_\_\_  
(Patient/Personal Representative Signature or Initial)

**20. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Hospital's Notice of Privacy Practices.

\_\_\_\_\_  
(Patient/Personal Representative Signature or Initial)

**I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.**

\_\_\_\_\_  
**Patient/Personal Representative**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature, Witness**

\_\_\_\_\_  
**Date**