HERITAGE VALLEY HEALTH SYSTEM
GENERAL CONSENT AND RELEASE FORM

1. CONSENT TO TREATMENT

Knowing that I have a condition that requires medical care, I authorize the physicians and other health care professionals who care for me to perform diagnostic procedures and to provide such medical treatment as necessary in their professional judgement. Diagnostic procedures and medical treatment include but are not limited to electrocardiograms, x-rays, physical therapy blood tests, and administration of medications. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees as to the outcome of any procedures, treatments or examinations have been made to me.

I understand that (a) it is customary, absent emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction, (b) each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course, and (c) no patient will be involved in any research or experimental procedure without his or her full knowledge and consent.

I understand that many of the physicians on the medical staff of the hospital are not employees or agents of the hospital but are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. I agree to permit medical, nursing, and other health care personnel in training, unless requested otherwise, to be present during patient care, or participate in patient care as part of their education.

If hospitalization is required, I will participate in the selection of the physician who will be responsible for my care while I am a patient in the hospital.

2. RELEASE FROM LIABILITY FOR VALUABLES (Check applicable statement)

☐ I am personally responsible for valuables in my possession including but not limited to, money, jewelry, checkbooks, credit cards or any other item of a personal, financial or sentimental value

☐ I have elected to secure valuables , as stated above within the hospital safe until return is requested by me, or upon my discharge.

3. REQUEST FOR PRIVATE ROOM *(Check if applicable)*

☐ ***I have requested a private room and agreed to pay the difference in rates upon discharge.***

Additional charge per day: ____________ ***Init*** _______

(Check those that apply) I acknowledge that I have received the following printed materials:

☐ Advanced Directive Information ☐ Message from Medicare/Medicare HMO ☐ Message from Champus ☐ Privacy Notice ☐ Patient Rights

4. ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby authorize payment of insurance benefits otherwise payable to me, but not to exceed balance due of the regular charges for this period of care to Heritage Valley and any physicians involved with my care. I understand that I am financially responsible for the charges not covered by my insurance.

A. TO BE COMPLETED BY OR ON BEHALF OF THE PATIENT (Complete Section A, B or C)

☐ I represent that I am an adult 18 years of age or over.

☐ I am an emancipated minor and may effectively consent to medical, dental, or other healthcare services under Pennsylvania Law, e.g.

a. _______ Graduate from high school, b. _____ am/have been married, (circle one) c. _______ am/have been pregnant, (circle one) d. _______ other (explain):

☐ I am the parent or legal guardian of the minor patient.

Date: _______/_______/_______ Time: ____________ AM / PM (circle one)

SIGNATURE of Patient / Parent / Legal Guardian ____ Init. __________ Signature of Witness ________________

B. SUBSTITUTED CONSENT

The patient is unable to consent because: ____.

I therefore consent for the patient Date: _______/_______/_______ Time:____________AM / PM (circle one)

Signature: ____ Relationship: ____

Signature of Witness: ____

C. TO BE COMPLETED IF AUTHORIZATION IS OBTAINED BY TELEPHONE

The above authorization has been read and explained via telephone to (Name) ____ who is (relationship to patient)_____________________________ Telephone authorization was given on Date: _______/_______/_______Time: __________________ AM / PM to (circle one)

(Signature of Staff Person)____

NOTE: If parent/legal guardian arrives in person, have him/her sign Section A.

5. AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and request that Heritage Valley provide to the insurance payers, including Medicare, which have been identified as being responsible for payment for this hospitalization or outpatient visit, any information that is necessary to determine whether my initial admission, continued hospitalization, or other care is medically necessary, or which is needed to process payment of my bill, and specifically includes the release of information for utilization review or post-discharge placement assessment purposes. This authorization extends to any organization acting on behalf of or in the place of the insurance companies. I understand that information that is released may include my entire medical record including reference to laboratory and other tests results including but not limited to blood alcohol, hepatitis, HIV and other communicable disease testing. I understand that my medical record may contain information related to:

*Acquired Immunodeficiency Syndrome, (AIDS) or infection with HIV *Psychiatric Care *Treatment for alcohol and/or drug use/abuse

UNDER REQUIRED REGULATIONS:
I GIVE CONSENT FOR RELEASE OF INFORMATION

SIGNATURE: ____ Date:________________

I also authorize the release of this same information to physicians and/or other health care facilities assuming responsibility for my care upon discharge or transfer from a Heritage Valley Facility necessary for my continued healthcare. This authorization will remain in effect for 90 days from date of discharge or until the account is financially settled unless revoked by me. I understand that I have the right to revoke this authorization at any time by communicating my revocation in writing to the Director of Medical Records. Heritage Valley will be held harmless from any losses, damages, or injuries that arise from actions taken in reliance upon this authorization prior to my revocation.

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HERITAGE VALLEY
HEALTH SYSTEM SM

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