ST JOHN PROVIDENCE

GENERAL CONSENT TO OUTPATIENT TREATMENT

CONSENT TO PHYSICIAN OFFICE, CLINIC, OR OUTPATIENT SERVICES

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues. If the specimen contains fetal tissue and you do not select a private funeral home, then SJP may send the tissue to the funeral home providing service to SJP where it will be cremated with other tissue from SJP.

I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including but not limited to ***commercial pharmacies i.e., Walgreen, CVS and alcohol and other drug treatment records*** for verification of my medications.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis B virus) tests may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

I expressly consent for the hospital, its providers and agents to place calls to my cellular and/or residential telephone using artificial or pre-recorded voice or auto-dialer technologies for any follow-up purposes, including billing and collections.

MEDICATION & MEDICAL DEVICE ASSISTANCE PROGRAM

In some cases, the hospital may be able to obtain reimbursement for some of your medications or medical devices from companies that manufacture them. In the event this occurs, the charge for the medication or medical device is removed from your bill for that hospital stay. Most of these programs require your signature on the application forms. In order to avoid you having to sign this application for each medication or device, we are requesting that you allow a Pharmacy Health Solutions ("PHS") representative to sign these forms on your behalf.

I appoint PHS to carry out in my name, the application forms required for PHS to obtain reimbursement for my medications or medical devices from manufacturers. This signature will be in full force from the date signed.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES

I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

Signature of Patient _____ **Date**_____ **Time** _____

Name of Patient (print) _____

Signature of Spouse_____ **Date**_____ **Time** _____

Signature of Witness_____ **Date**_____ **Time** _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_____ **Date**_____ **Time**_____

Relationship_____

Address_____Phone Number _____

Signature of Witness_____ **Date**_____ **Time**_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

The St. John Providence Notice of Privacy Practices and Patient Rights and Responsibilities provides information about how protected health information about me (the patient) – may be used and disclosed. I understand that the terms of the Notice may change and that I may obtain a current copy by accessing the St. John Providence website at www.stjohnprovidence.org or by contacting the Privacy Officer listed in the Notice.

The Patient Rights and Responsibilities handout provide information about patient rights, benefits, or privileges guaranteed by law. I understand that the law may change and that I may obtain a current copy by accessing the St. John Providence website at www.stjohnprovidence.org or by contacting the Patient Relations Department.

I acknowledge that I have been provided the St. John Providence Notice of Privacy Practices and the Patient Rights and Responsibilities handout.

Name of Patient (print) _____

Signature of Patient _____ **Date**_____ **Time**_____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative_____ **Date**_____ **Time**_____

Relationship_____