ST. MARY'S MEDICAL CENTER

PT #:
MR#:

Patient Consent

1. Consent for Admission, Testing, and Treatment. I give St. Mary's Medical Center, Inc. and any treating physician and/or health care provider to administer such anesthetics and medication and/or to perform such medical and/or surgical procedures which are deemed necessary by my healthcare team. I give my permission to be admitted as an inpatient if so ordered by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the hospital.

2. Account Responsibility. I accept responsibility for payment of all charges and fees for hospital and professional services covering hospitalization and/or outpatient/emergency services of the below named patient. I (we) also accept responsibility for payment of all professional services provided to me during my stay by providers who are not employed by St. Mary's Medical Center and that separate bills may be generated by these service which include but are not limited to physicians, emergency medicine, anesthesia, and diagnostic and laboratory services.

I further authorize that any insurance benefits be paid directly to the institution which provided the services. I (we) agree to the release and disclosure of medical information required to verify coverage or process insurance claims. St. Mary's will bill your insurance carrier on your behalf for charges related to the services provided by our employees in our facility. We are not responsible for the handling of claims by the other providers rendering services to you while at St. Mary's. You will receive a bill from those institutions separately. Please note that you are responsible for the full amount of your account that is not covered by insurance (with the exception of certain government insurance plans).

If I am a Medicare Patient, I certify that the information given by me in applying for payment under Title XVII 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 or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

3. Release Disclosure and Use of Patient Information. I authorize St. Mary's and my physicians to access information about my prescriptions from any health care provider or benefits manager including prescriptions that have been submitted for claims to any insurance plan. I authorize St. Mary's to receive or release my health information, whether written, verbal, or electronic to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care. In addition, if at any time, I provide a wireless telephone number to St. Mary's at which I may be contacted, I consent to receive calls (including autodialed calls, prerecorded messages and automated appointment reminders) at that wireless number from St. Mary's, its affiliates, agents and independent contractors, including collection agents, regarding the services rendered, hospitalization, and/or my related financial obligations.

4. Patient Rights and Notice of Privacy Practices. I have received a copy of St. Mary's Medical Center's Patient Rights as well as the Notice of Privacy Practices.

5. Medication History. I authorize St. Mary's and my physicians to access information about my prescriptions through a prescription exchange called SureScripts. This information helps St. Mary's care for me in a safer and more efficient manner, especially if I am unable to tell the exact names and dosages of my medications

( ) **Request** for Private Room Assignment: I request that St. Mary's Medical Center assign me a PRIVATE room and I agree to pay the difference between the semi-private and private room rates.

_____ _____

Signature Witness

_____ _____

Relationship to Patient Date Time

CONSENT FOR ADMISSION

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Adopted Date:

Revised Date: 7/11;4/13;7/13;11/13;4/16

Reviewed Date:

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
«Gender» / «BirthDate»
«PatientAddress1» / «AttendingDoctorName»
«Room» / «MedicalRecordNumber»

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