ROOKS COUNTY
RCH
HEALTH CENTER

Patient Name:_____ Date of Birth:_____

Account No./Medical Record No.:_____ Admission Date:_____

TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

The term "Hospital" includes the Hospital's acute care, swing bed unit, long term care unit, emergency department, outpatient surgery, and outpatient departments.

1. CONSENT FOR TREATMENT: I consent to radiographic and ultrasound examinations, laboratory procedures, anesthesia, medical treatment, surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I also consent to the presence of other medical and paramedical personnel, which may include medical and paramedical personnel participating in training programs through the Hospital's partnership with area training programs (for example, residents, nurses, CRNAs) during the operation, procedure, or delivery of services. I understand that my treatment is under the control of my attending physicians, their assistants or designees. I understand that if I desire private duty nursing care, I or my family must arranged for such care, and the Hospital shall be released from any and all liability arising from such care. I understand that I will be asked to provide specific consent for certain diagnostic studies, surgeries or other treatment procedures. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services. I understand that any licensed medical personnel involved in the operation, procedure, or delivery of services will act within the scope of their licensure.

2. CONSENT FOR NEWBORN TREATMENT: Upon the birth of my child, I consent to radiographic and ultrasound examinations, laboratory procedures, anesthesia, medical treatment, surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my or my child's attending or consulting physicians and agree that all the provisions of this Treatment Authorization will be applicable to my newborn.

3. CONSENT FOR BLOOD/BODY FLUID TESTING: I consent to have the Hospital determine by laboratory testing whether or not my blood contains contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health, the health of my family, or the health of any health care personnel or emergency response person(s) who may have been exposed to my blood or bodily fluids.

4. CONSENT FOR PHOTOGRAPHY, AUDIO, VIDEO RECORDING. I agree that medical images, photographs, audio recording, digital recording or video recording may be made while I am receiving treatment in the Hospital. I understand that the images and audio from such photography and recording may be used for my treatment or for Hospital operations. The use of such images and audio is subject to the following limitations: _____ (if made photographs, audio recording, digital recording and video recording will be included in your health record, list any other place or publication where you do not wish them used, for example newspaper, on-line publications, our website, etc.).

5. AGREEMENT TO PAY FOR SERVICES: I agree that in consideration of services to be rendered to me or to the patient for whom I am signing this authorization, I hereby obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms. I am aware that any patient coming to the Hospital will have a medical screening examination performed regardless of the ability to pay. I also understand that services may be provided by individuals who are not employed by the hospital who will bill me separately for their services.

6. 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.

7. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign insurance benefits otherwise payable to me 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.

8. 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.

9. PERSONAL VALUABLES/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.

10. REPORTING CERTAIN DISEASES: Certain diseases and conditions, including cancer, are required by law to be reported. I understand that the Hospital will comply with its legal reporting obligations by submitting the necessary information to the proper authorities.

11. DENTURES: I understand that the Hospital will provide a denture cup if I require it. I will take precautions to be sure my dentures are properly kept and cared for during my hospitalization and I will keep them in the denture cup when I am not wearing/using them.

12. CONTRABAND WEAPONS/DRUGS: I agree that should the Hospital find contraband weapons, nonprescription drugs that are not sold over-the-counter, or any other type of contraband with my possessions, on or near my person or in my room, these items will be confiscated and the police will be contacted.

13. USE OF APPLIANCES: I agree that using any electrical appliance that is not owned by or under the control of the Hospital is done at my own risk and I hereby release the Hospital from any and all responsibility for injuries or property damage which may result from the use of said appliance.

14. PROVIDER NON-DISCRIMINATION ACT: I understand that Hospital is an equal opportunity institution and will not discriminate because of race, color, religion, natural origin, age, sex, sexual orientation, handicap, or ability to pay.

15. NOTIFICATION OF PHYSICIAN AVAILABILITY: As a Critical Access Hospital, there is no physician physically present within the hospital 24 hours per day, seven days per week to assist patients in making informed decisions on their care. The hospital meets the medical needs of a patient who develops an emergency medical condition by utilizing physicians or mid-level practitioners on call.

16. MEDICARE/TRICARE PATIENTS ONLY: I have received a copy of "An Important Message from Medicare/Tricare" and understand my rights as described in that document.

17. PATIENT RIGHTS INFORMATION: I have reviewed/received *Patient Rights and Responsibilities* and understand my rights as described in that document.

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

19. ADVANCE DIRECTIVE INFORMATION: (complete for all patients including outpatients)

	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?		

20. CONSENT FOR CONTACT BY LANDLINE OR CELLULAR TELEPHONE NUMBER. I hereby consent to Hospital, or its agents or representatives, contacting me by the following means (even if the Hospital, or its agents or representatives, initiate contact using an automated telephone dialing system (ATDS) and/or an artificial or prerecorded voice): (1) paging system: (2) cellular telephone service; (3) landline; (4) text message; (5) email message; or (6) facsimile.

21. PRESCRIPTION HISTORY CONSENT. I agree that Hospital may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

22. 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)

23. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I hereby acknowledge that there is a copy of the Hospital's Notice of Privacy Practices available to me so that I may take it with me.

_____

(Patient/Personal Representative Signature or Initial)

I certify that I have read and fully understand this document. I understand that a copy of this document is available to me.

I, individually, or as the patient's personal representative, by signing this document agree that I agree with all of its content.

_____	_____	_____
Patient/Personal Representative	**Relationship to Patient**	**Date/Time**

_____	_____
Signature, Witness	**Date/Time**