National Health System

Sample Consent and Agreement of Health Care Services

CONSENT FOR TREATMENT I consent to and authorize National Health System's entities and physicians to provide healthcare services under the general and specific instructions of members of the medical staff. At the discretion of the professional staff, I further consent to any examinations, tests or procedures that may be deemed advisable or necessary in the diagnosis and treatment. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I authorize the Entity and my physicians to take photographs, or other images, of me or parts of my body to be used in medical evaluations, education or research. I also authorize the use of video/audio technology (e.g. eiCU, eHospitalist, eConsults and other eHealth/telemedicine services) to monitor, assess and interact with me while under the care of the Entity to be used in medical evaluations, education or research. The Entity does not routinely test all patients for hepatitis or for the human immunodeficiency virus (HIV). However, in the event that my physician feels it is necessary or in the event that a health care worker, employee, or volunteer is exposed to my blood or other body fluids; my blood may be tested for hepatitis or HIV infection. If my blood test indicates infection, my physician will be notified.

PROFESSIONAL CARE The patient is under the professional care of an attending physician who arranges for services in the care and treatment of the patient. I realize that those who provide patient care at this Entity are medical, nursing and other health care personnel in training who may be participating in patient care as part of their education.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the release of all or any part of the patient's medical and accounting record which may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges. I also authorize the Entity to release information needed for billing purposes to physicians or entities that provide services to me related to my admission to the Entity. I also authorize the System to review my medical records to gather data for research purposes. I understand that no information that will identify me in any way will be published. I also consent to the sharing of my health information within the National Health System for the purposes of treatment, payment, and healthcare operations.

ASSIGNMENT OF BENEFITS I hereby assign to National Health System's entities and any or all physicians; all of my interest and right to the insurance benefits otherwise payable to me for this hospitalization or outpatient services arising out of any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of hospital benefits (including major medical) directly to the hospital, which provided care. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim for payment. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering said hospitalization or outpatient service and that the Entity is not responsible for precertification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of precertification and/or any charges not covered by this assignment of benefits.

AUTHORIZATION TO FILE AN APPEAL ON PATIENT'S BEHALF I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and they may deny payment of a portion of my Entity billing. To assist me in resolving this dispute, I authorize the Entity to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to also notify the Entity directly of the determination of such grievances or appeals.

FINANCIAL RESPONSIBILITY In consideration of the Entity and the physicians supplying or furnishing hospitalization, Entity services and physician services; I promise to pay the Entity and the physicians for such hospitalization, Entity services and physician services supplied and furnished heretofore or to be supplied and furnished to said patient. I understand that the acceptance of insurance assignments does not relieve me from any responsibility concerning payment for said services and that I am financially responsible to the Entity and physicians for the charges not covered by the policy of the insurance or self-insured health plan. I also understand, pursuant to the hospital lien statutes of this state, if my injuries were caused by the negligence or wrongful act of another, National Health System may have a lien on any and all claims or rights of action I may have against the person causing my injuries, and National Health System may have the right to enforce the lien for payment of services rendered rather than seek payment from my insurance or self-insured health plan. In the event of collection, the cost of collection, including reasonable attorney fees and court costs shall be included as part of the obligation due National Health System's entities and physicians.

FINANCIAL ASSISTANCE The hospital has a financial assistance policy for which you may qualify. The income guidelines are based on Federal Poverty Limits. If your income is less than the guideline for your family size, you may qualify for assistance.

GENERAL TERMS

Behavior Expectation: I agree that it is my responsibility to treat other patients, visitors and staff with respect. I understand that disrespectful behaviors will not be tolerated and may lead to evaluation for my discharge.

Patient Label:

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National Health System

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Consent to Contact: I understand that SLHS or its collection agent may contact me at the phone number provided below regarding any unpaid balance on my account (even if the number is a mobile or cellular number) including by means of an autodialed and/or pre-recorded collection call, and I hereby consent to same. I understand that my consent to receive such calls is not a condition of treatment.

Exit agreement: I have been informed and agree that I will voluntarily exit from National Health System when it is determined in the medical judgment of my physician or the Hospital's Utilization Review Committee that I no longer need to remain under care.

Release of responsibility for valuables: I understand the Hospital strongly recommends that all personal belongings and valuables be sent home or placed in the hospital's security for safekeeping until discharge. I understand the Hospital shall not be liable for loss or damage to any personal property I may choose to keep with me and will not replace any personal items if they are lost or stolen.

Tobacco Free Policy:

☐ I understand that all National Health System campuses are tobacco free. I acknowledge that I may not smoke or use any Tobacco products anywhere on the campus, including the parking lot or grounds of the facility. If I make the decision to go off campus to smoke or use tobacco products, I take full responsibility for my own safety. I agree not to hold the Entity or any of its employees or agents responsible if I am injured in any way as a result of my decision to smoke or use tobacco products. State and Federal laws will be followed regarding smoking by minors. This tobacco free policy applies to a-cigarettes, vaping products and other alternative tobacco and nicotine products.

Patient satisfaction survey: National Health System may contact you regarding the care you received and use this information to improve the quality of care we deliver. This survey may be provided via a telephone call or by email with a link to a secure website where you may provide anonymous input. You may also receive an email inviting you to enroll in our online patient portal, where you can securely communicate with your physician, get lab results and visit summaries, and more.

Patient/Representative has been provided with: ☐ Patient Refused

☐ Advance Directive information
☐ Patient Handbook
☐ Patient Safety brochure
☐ Financial Assistance Policy (FAP) Summary Provided
☐ Patient Advocacy/Patient Rights/Grievance Procedure information
☐ Skilled Nursing patient has been given "Welcome Letter" and "Grievance Procedure" (as applicable)

I understand that I have the following rights regarding my information:

- To receive the Notice of Privacy Practices prior to this consent.
  ☐ Notice Provided
  ☐ Refused Notice
- To object to the use of my health information in the hospital signing Directory (If YES, Patient removed from the directory)
  Facility Directory Listing Opt-Out ☐YES ☐NO ☐N/A
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I/We hereby certify that I/we have read all parts of this Consent and Agreement and accept all terms and conditions and state that all representations made by me are true.

____
Name of Patient

____
Patient phone number

____
Signature of Patient Date/Time
Or authorized representative (include relationship to patient)

____
Witness Date/time

Patient Label:

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