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I. GENERAL CONSENT TO TREATMENT AND TESTS:

A. I have been referred for care (treatment, testing or otherwise) at this Baptist facility (the facility). I permit my physicians, the facility and its employees and others involved in my care to provide such treatment, testing or care in ways they judge beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent. I consent to examinations, x-rays, blood tests, including blood tests for communicable diseases such as hepatitis and AIDS (including testing where health care personnel have been exposed to my blood and body fluids), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, radiation therapy and other services or treatments rendered or ordered by my physician, consulting physicians and their associates and assistants, or rendered by the facility's employees under the instructions, orders or direction of such physician(s). I understand that State law requires reporting of certain positive test results, such as hepatitis and the antibody for the AIDS virus, to the Health Department.

B. If the facility participates in the training of medical students, interns, residents, fellows, or allied health care personnel, I consent to the observation of and participation in my care by such medical personnel in training.

C. I acknowledge that the hospital in certain instances uses reprocessed devices (devices that are cleaned, disinfected or sterilized between uses) that are marketed by their manufacturers as "single use" devices, a practice that is permitted and regulated by the US Food and Drug Administration. I accept and consent to the use of these devices and supplies during any surgery and/or other procedure performed on me.

D. I permit my physicians, the facility and its employees and others involved in my care to take photographs, film or videotape of me for clinical, performance improvement and/or risk management purposes. All such photographs, films or videotape shall become part of my medical record and subject to the privacy laws applicable to medical records.

E. **I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my treatment, testing or other care.**

II. INDEPENDENTLY PRACTICING DOCTORS AND OTHER HEALTH CARE PROFESSIONALS:

A. I understand that my admitting and consulting physician(s), radiologist(s), pathologist(s), emergency department physician(s), anesthesiologist(s), podiatrist(s), psychologist(s), allied health professionals employed by physicians or other corporations and private duty nurses (and sitters) are engaged in the practice of their professions on behalf of themselves or other corporations and are not employees or agents of the facility. I understand that I may receive bills for their professional services in addition to bills I receive from the facility.

B. I also understand that the facility permits various educational institutions to train medical students, interns, residents, fellows and other health care professionals at the facility. I consent to the observation and participation of all such personnel in my care. I understand and acknowledge that while these personnel practice on the facility's premises, use the facility's equipment, and are subject to the facility's administrative rules and protocols, they are NOT employees or agents of the facility. The facility is not responsible for their acts or omissions, and I will not attempt to hold the facility responsible for their acts or omissions. If I want to know the employment status/affiliation of any health care provider, I will ask questions to satisfy myself of their status sufficient to make informed decisions regarding the employment status/affiliations of the various health care providers.

C. I understand that my physician(s) and other health care providers may have financial interests in various health care ventures. I understand that I have a right to question any health care professionals involved in my care about whether they have any such interests that might affect my care.

D. I acknowledge that I may receive treatment from hospital-based physicians who do not participate in my insurance plan and that I may receive a separate bill from such physicians for the amount unpaid by my insurer.

III. RELEASE FROM LIABILITY FOR LEAVING OR REFUSING CARE AGAINST MEDICAL ADVICE:

I agree that if I leave the facility or refuse care against the advice of my physician or facility personnel, then the facility, its personnel, and my physician(s) are released from any responsibility or liability for any injuries or damages which may result from my leaving or refusing care.

IV. FOLLOW-UP CARE REFERRAL:

I understand that I have the right to choose the agencies that will provide any needed follow-up care, supplies or equipment. If I do not make a choice, I authorize the facility to make referral arrangements on my behalf, including referral to agencies affiliated with the facility.

V. AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION:

A. I understand that my medical information may be maintained in an electronic medical record to enable Baptist facilities and care providers throughout this health care system to more readily obtain access to the information. I understand that I will receive a Notice of Privacy Rights from the facility that addresses the ways in which the facility may use my health information for treatment, payment, and health care operations purposes. Please acknowledge your receipt of the Notice of Privacy Rights on the reverse side of this form.

B. I permit the facility to acknowledge that I am or have been a patient, unless I have specifically instructed the facility to withhold such information.

C. I intend for this authorization to apply to my present, past, and future admission at Baptist facilities.

D. I understand and agree to the presence of individuals from outside organizations in the patient care area if indicated while I am undergoing services at this facility.

E. Third Party Liability/Workers Compensation: I authorize Baptist to disclose my entire medical record for today and any follow up visits related to the injury for which I am requesting treatment. Further, I understand that my employer's insurance company may request past visits as part of their investigation and discovery process to determine what workers compensation benefits I'm owed. The disclosure of my personal health information may include, but not be limited to, information regarding my diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV).

F. Employment Screenings: I request and authorize Baptist to disclose my employment physical and/or drug screen results to my potential employer (for pre-employment screenings) or current employer (for random screenings, fitness for duty, etc). I understand that the disclosure of my personal health information may include, but not be limited to, information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV).

G. I understand that I have the right to revoke any authorization provided under this Section V at any time, except to the extent that release of information has already occurred in reliance on my prior authorization. I understand that in order to revoke an authorization, a written document declaring the revocation must be delivered in person or by certified mail to the Director of Health Information Management at the Baptist facility indicated above. The revocation document must contain your or your legal representative's original signature. I understand that authorizing the disclosure of health information is voluntary and that I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as payment, enrollment or eligibility for benefits. My refusal to authorize release of my information may adversely affect payment for the services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form. I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

H. I understand that my bill may come from the facility or an affiliated Baptist entity or group.

VI. FINANCIAL RESPONSIBILITY:

The undersigned, jointly and severally, in consideration for the services rendered to the above named patient, accept financial responsibility and agree to pay in advance any applicable deductibles, copayments, coinsurance and estimated self-pay dollars and to pay in arrears the facility's and my physician's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agree that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance.

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**GENERAL CONDITIONS CARE AND TREATMENT RECORD**

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VII. COMMUNICATIONS REGARDING MY ACCOUNT: initial here: _____
**I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.**

VIII. ASSIGNMENT OF INSURANCE BENEFITS:
A. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act, or under other insurance coverage, is correct. I request that payment of authorized benefits be made on my behalf to the facility and other providers.
B. I transfer and assign to the facility and to my physicians and other providers and entities providing special services which may be covered by the third party payer, all of my rights to benefits payable to me or to a beneficiary under all applicable policies of insurance or health plan(s) listed with the facility at registration, and those not listed and which are later determined to provide coverage, but not to exceed the facility's or other providers' regular and customary charges for services. By this assignment, I authorize payment directly to the facility and directly to other providers and entities providing special services. **I understand and agree that if any part of my account is not paid by insurance, for whatever reason, I am still financially responsible for the indebtedness.** It is my responsibility to take the action necessary for such benefits to be paid to the facility and other providers.
C. If a third party or his/her/its insurer is liable to me for my injuries and expenses, including my facility charges, I authorize and direct such third party and insurer to withhold from any settlement or judgment which I may recover, such sums as are due and owing to the facility for services rendered to me, and such sums are hereby assigned to the facility and are to be paid directly to the facility by such third party or insurer. I understand that I am fully responsible for the facility charges and this does not relieve me of my personal responsibility to pay the charges when due.

IX. ORGAN DONATION:
I understand I have the right to donate my organs.

X. TISSUE DISPOSAL:
I authorize the facility to retain or dispose of tissue removed from my body (including fetal or afterbirth tissue of obstetrics patients) in accordance with its usual procedures.

XI. PERSONAL VALUABLES:
I understand that it is my responsibility to arrange for the safekeeping of my money, jewelry, valuables, or other items of property and agree that the facility is not responsible or liable, directly or as an employer of others, for damage to or loss of money, jewelry, valuables or other items of personal property, regardless of the cost, unless I have deposited such items with the facility and the facility has agreed to hold the items for safekeeping. **This release from responsibility includes any loss of or damage to dentures, bridgework, clothing, eyeglasses, contact lenses, prostheses, jewelry, money and all other items of personal property.**

XII. GENERAL INFORMATION AND AUTHORIZATION:
A. This is to certify that I have been given a copy of my rights and responsibilities as a patient in this facility.
B. For Medicare beneficiaries admitted to the hospital: I have received a copy of the Important Message from Medicare.
C. If my insurance requires admission or pre-admission certification, I understand it is my responsibility to complete this process or have my attending physician complete this process.

**(Mississippi Facilities Only):**
D. I hereby authorize the facility to retire x-ray film and any other graphic data, which may be generated during my care (treatment, testing or otherwise) four years after the time generated if a proper report is in the medical record.
E. For **Medicaid obstetrical patients** (Filing claims for Newborn; OBRA 90): Will the newborn child be in the household of the mother?

YES _____ NO _____ N/A _____

XIII. SEVERANCE OF INVALID TERMS:
I understand that if any provision of this Agreement shall be prohibited by or be invalid under applicable law, such provision shall be ineffective to the extent of such prohibition and the remaining provisions shall remain effective and enforceable.

Please place your initials by the appropriate responses:
XIV. I permit the facility to acknowledge that I am a patient. YES _____ NO _____

XV. Acknowledgement of Notice of Privacy Rights

_____ I received a copy of the Notice of Privacy Rights.

_____ I previously received a copy of the Notice of Privacy Rights and understand that additional copies of the Notice are available for review.

I have read and understand this document and agree to its terms. I further acknowledge that I have been given the opportunity to 1) ask questions regarding my financial liability under this agreement and 2) ask for a determination if I qualify for financial assistance programs.

| | | |
|---|---|---|
| SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT | RELATIONSHIP TO PATIENT | DATE/TIME |
| SIGNATURE OF GUARANTOR/RESPONSIBLE PARTY | RELATIONSHIP TO PATIENT | DATE/TIME |
| WITNESS | DATE/TIME | |

For Facility Use Only:
If Acknowledgement of receipt of Notice of Privacy Rights not obtained, please note reason:

_____Medical Emergency _____Refused to Sign _____Unable to sign because

Employee signature: _____ Date: _____

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**GENERAL CONDITIONS CARE AND TREATMENT RECORD**

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