St. Vincent Hospital

GENERAL CONSENT FOR MEDICAL TREATMENT

1. **CONSENT FOR HEALTH CARE SERVICES:** I voluntarily consent to and authorize the rendering of health care services, including routine hospital services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, including the use of restraint, which my attending physician or others holding clinical privileges and consider necessary. I understand that health care services may be rendered by students, interns, or residents under physician supervision. I further understand that the practice of medicine in not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility. I acknowledge that by State law, in the event of a health care worker in our facilities is accidentally exposed to my blood or body fluids, my blood will be tested for the presence of HIV antibodies.

2. **AUTHORIZATION FOR RELEASE OF INFORMATION:** I authorize the hospital and my physicians to release information from my medical records to any health care provider involved in any way in my care and treatment and to any person or entity which is or may be liable for all or part of the hospital charges, including but not limited to my insurance carrier, any third party provider, the Medicare/Medicaid programs, and my employer's Workers' Compensation carrier. I also authorize the release of information needed for discharge planning, transfer, and follow-up purposes.

3. **MEDICARE AND/OR MEDICAID CERTIFICATION:** I certify that the information given to me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the hospital on my behalf for the hospital's and physician's charges for which the hospital and physician is authorized to bill in connection with these health care services.

4. **RETENTION OF SPECIMENS:** I authorize the hospital to take, retain, preserve, and use for scientific or teaching purposes, or dispose of at its convenience, all specimens, tissues, parts, or organs taken from my body during hospitalization.

5. **INDEPENDENT PRACTITIONERS:** I understand that I may be billed separately by professionals, including but not limited to Emergency Department physicians, radiologists, pathologists, and anesthesiologists, who are independent contractors and are not agents or employees of the hospital for health care services rendered to me. I further understand that it is my responsibility to verify my insurance benefits and coverage, if any. **_____(initial)**

6. **FINANCIAL AGREEMENT:** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payers. I acknowledge full financial responsibility for, and agree to pay all charges of the hospital and of physicians rendering services not otherwise paid by health insurance or other payers. All charges are due and payable upon receipt of the bill. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will be forwarded to the address on file with the hospital.

CONSENT TO WIRELESS TELEPHONE CALLS: By signing below, I consent to be contacted by regular mail, text, by email or by telephone (including a cell phone number) regarding any matter related to the referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto dialer or unattended dialer technology and/or prerecorded messages.

7. **PREAUTHORIZATION REQUIREMENTS:** I understand that it is my sole responsibility to obtain all preauthorization and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the hospital's and physician's charges. **_____(initial)**

8. **ASSIGNMENT FOR DIRECT PAYMENT:** I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the hospital and my physicians, to include any hospital-based radiologists, pathologist, anesthesiologists, and Emergency Department physicians. I understand that I am financially responsible to the hospital or my physicians for charges not covered or paid pursuant to this authorization.

9. **PERSONAL VALUABLES:** The hospital maintains a safe for the safekeeping of any money or valuables. I understand the hospital does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, false teeth, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other items unless such money or property is deposited with the hospital. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the hospital. **_____(initial)**

Governmental Immunity Notice: Medical care and other health care at St. Vincent General hospital may be provided by individuals who are considered public employees by the Colorado Government Immunity Act. The Colorado Governmental Immunity Act, Article 10 of Title 24 of the Colorado Revised Statutes, limits the amount of damages recoverable from public employees and entities, requires a formal notice of a claim, and places a 180-day time limit on the period for filing such a notice of claim.

LIVING WILL/DURABLE POWER OF ATTORNEY?:	**YES NO**	**COPY OF MEDICARE RIGHTS GIVEN?:**	**YES NO**
HOSPITAL HAS A COPY?	**YES NO**	**ADVANCE DIRECTIVES GIVEN?:**	**YES NO**
PATIENT RIGHTS/RESPONSIBILITIES GIVEN?:	**YES NO**	**PRIVACY RIGHTS GIVEN?:**	**YES NO**

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON AUTHORIZED BY PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON **PRINT NAME**

_____ _____

RELATIONSHIP/REASON WHY PATIENT UNABLE TO SIGN **DATE** **TIME**

_____ _____

WITNESS SIGNATURE **DATE** **TIME**