

ROCKDALE MEDICAL CENTER
GENERAL CONSENT TO TREAT AND FINANCIAL AUTHORIZATION
DO NOT SIGN THIS FORM WITHOUT READING AN UNDERSTANDING ITS CONTENTS

NAME OF PATIENT: _____

DATE OF CONSENT: _____

A. CONSENT FOR PROCEDURES AND TREATMENT:

I/The Patient hereby grant permission to Rockdale Medical Center, Inc. and its affiliates, agents, physicians and employees (hereinafter collectively referred to as "Rockdale"), Radiology Physicians, Emergency Physicians, Anesthesia Services, Pathologists, Hospitalist, my physician and/or physicians associated with him/her and any other individual whom he/she may designate (collectively "Providers") to provide assessment, testing, care and treatment on an inpatient and outpatient basis. I acknowledge the practice of medicine is an inexact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME regarding my/the Patient's care and treatment at Rockdale or the results of such assessment, testing, care and treatment.

The Routine Procedures and Treatments referenced in this form may include, but are not limited to, the following:

(a) **Needle sticks, Shots, Injections or Intravenous Fluids** and other similar procedures which may be utilized to deliver medication or fluid into the body in the course of patient treatment. Usually, medications and fluids are injected just under the skin, into the veins(s) or the muscles. Medications are often added to the body through an intravenous ("IV") line, if applicable. The risks associated with these types of routine procedures include, but are not limited to, discomfort, bruising, scarring, infection, nerve damage, infiltration (leakage of fluid into nearby tissue), tingling, burning or partial paralysis, tissue loss, transmission of disease, and thrombosis. Alternatives to intravenous injections or fluids include oral, rectal, nasal, or topical medications, which may be less effective, or refusal of treatment.

(b) **Non-invasive radiographic procedures** such as x-ray, CT scan, MRI, sonogram, ultrasound and other similar procedures, which may be utilized in conjunction with diagnosis and treatment. Radiographic procedures also include radiation therapy. The risks associated with these types of routine procedures include, but are not limited to, discomfort, radiation exposure and physical injury. Apart from using an alternative type of radiographic procedure or refusal of treatment, no practical alternatives exist.

(c) **Physical tests, assessments, therapies and treatments**, such as internal body exams, range of motion checks, wound cleansing, stitches, wound dressing, catheters, enemas, respiratory and physical therapies, rehabilitation procedures and other similar procedures, which may be utilized in conjunction with diagnosis and treatment. The risks associated with these types of routine procedures include, but are not limited to, reactions to the material(s) used, discomfort, soreness, injury to bone or muscle, and worsening of the condition, including infection, scarring, and/or re-injury and loss of limb function. Apart from using modified procedures or refusal of treatment, no practical alternatives exist.

(d) **Medications** which may be utilized in the care and treatment of patients, whether administered orally, rectally, topically or through eye, ear or nose. The risks associated with medications include, but are not limited to, drug interactions, drug intolerance, allergic reactions, adverse reactions including death, both long-term and short-term side effects which vary from medication to medication, inexact dosage calculations and/or methods of delivery, perforation, puncture, infection, brain damage, and/or paralysis. Apart from varying the medication prescribed, the method of delivery or refusal of treatment, no practical alternatives exist.

(e) **Laboratory testing** may be utilized when taking samples of blood, bodily fluids and tissue samples for laboratory analysis. The risks associated with these types of routine procedures include, but are not limited to, those risks listed above in section (a) for needle sticks. Apart from long-term observation or refusal of treatment, no practical alternatives exist.

(f) **Assessments, Monitoring and Daily Care** such as vital signs, baths and other general hygiene care, physical exams, application of monitors and other devices, and transportation of the patient to/from various hospital areas or departments. The risks associated with these types of routine procedures include, but are not limited to, discomfort, falls, injury, and loss of personal privacy. Apart from using modified treatments or procedures or refusal of same, no practical alternatives may exist.

In addition to the treatments and procedures listed, I understand there are other treatments and procedures which are commonly performed on hospital patients and outpatients. The risks of these treatments and procedures can include discomfort, pain, bleeding or severe loss of blood, bruising, soreness, physical injury, worsening of condition, infection, allergic reactions, adverse reactions, loss of personal privacy, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest or death. Apart from using modified treatments or procedures or refusal of same, no practical alternatives may exist.

B. ACKNOWLEDGMENT THAT PHYSICIANS AND THEIR ASSISTANTS ARE NOT EMPLOYEES OF "ROCKDALE":

I/The Patient fully understand that some or all of the Healthcare Professionals performing services at Rockdale, including Physicians, Emergency Department Physicians, Radiologist, Pathologists, other Specialists, consulting and attending Physicians and their Assistants (such as Physician's Assistants and Nurses), are NOT HOSPITAL EMPLOYEES OR AGENTS, but are Independent Contractors or are employed by the Independent contractors. This is true even for Physicians that may be assigned to the patient, or provided service to the patient without the patient's knowledge. I, the Patient agree and understand that independent contractors are responsible for their actions and Rockdale does NOT control and is NOT responsible or liable for acts or omissions of any such independent contractor. Some or all of the health care professionals performing services in this hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors.

C. DISCLOSURE OF HEALTH INFORMATION AUTHORIZATION:

USE AND DISCLOSURE OF INFORMATION: I hereby authorize Rockdale and the Providers to disclose my health information, data and records via mail, telephone, electronic, or fax, including, but not limited to, information which may be deemed confidential or privileged by virtue of state and/or federal law or regulation [such as a diagnosis of human immunodeficiency virus infection ("HIV+") or Acquired Immune Deficiency Syndrome ("AIDS"), information that would indicate diagnosis or treatment for alcohol and/or substance use or abuse, psychiatric or psychological conditions], to those individuals and/or entities authorized by me (or on my behalf) or which have a right to such information by operation of law, including but not limited to health insurance companies, third party payors, government or social service agencies which may or will pay for any part of the medical/hospital expense. The purpose of such disclosures is to facilitate my/the Patient's treatment and payment. This consent is subject to revocation at any time except to the extent Rockdale or the Providers have already taken action in reliance on it. If not previously revoked, this consent will terminate in one (1) year from the date of this consent, or until such time as my/the Patient's treatment by Rockdale and the Providers is concluded and all such bills are fully paid, whichever is later.

D. CONSENT FOR STUDENT OBSERVATION OR ASSISTANCE:

I consent that students in training, including but not limited to fellows, residents and interns, may observe or assist in the procedures which will be performed on me/the Patient at Rockdale. I/The Patient also consent to representatives of manufacturers, vendors or other companies observing the procedures which will be performed on me/the Patient at Rockdale.

E. RELEASE OF LIABILITY FOR PERSONAL VALUABLES:

The undersigned understand and agree that valuables, including jewelry, glasses and dentures, should be kept at home and should not remain at Rockdale. Rockdale has a safe and is willing to hold valuables upon request, but Rockdale is not liable for loss or damage to any money, valuables, personal belongings or any other article considered a valuable. Rockdale staff issue receipts or other documentation when accepting items for holding in the safe. When not in use, it is the responsibility of the Patient and/or the Patient's family to make sure dentures, bridges, glasses, contact lenses, and hearing aids are placed in protective containers since Rockdale cannot be responsible for the breakage or loss of such articles.

F. CONSENT FOR DISPOSAL OF HUMAN TISSUE: I/The Patient agree that any specimens, tissues, body parts, products of conception, and fetal remains may be examined, retained, preserved, used for scientific teaching purposes, autopsied or disposed of at their convenience by Rockdale and any physicians, agents or employees.

G. ACKNOWLEDGEMENT OF GREIVANCE PROCEDURES:

I/The patient have been provided information on the grievance process and complaint procedures for external state authorities and the internal Rockdale complaint procedure. I have been allowed to ask questions about the grievance process and complaint procedures and any questions have been answered and explained to my understanding.

H. CONSENT TO PHOTOGRAPH, VIDEOTAPE, RECORD, FILM AND AUDIOTAPE:

By signing this Form, I/the Patient authorize and consent to Rockdale, its affiliates, governing bodies, officers, directors, medical staff, agents and employees to photograph, videotape, record, film and/or audiotape me/the Patient during interviews, diagnostic and/or treatment sessions and surgical or medical procedures, for use by Rockdale for internal purposes, including but not limited to patient safety, identification, treatment, performance improvement and education. I understand that I/the Patient will be provided a specific separate consent form in order for a photograph, videotape, record, film or audiotape to be made of me/the Patient for external publication purposes.

I. PATIENT SELF DETERMINATION ACT: I have been furnished information regarding Advance Directives for a "Living Will" and the patient's rights and responsibilities and other information related to my stay.

Please INITIAL (at least one) the following statements which are correct:

- _____ 1. I executed an Advance Directive and have been requested to supply a copy to the hospital.
- _____ 2. I have NOT executed an Advance Directive.
- _____ 3. I wish to execute an Advance Directive.
- _____ 4. I do NOT wish to execute Advance Directives.

J. CONTINUING AUTHORIZATION FOR OUTPATIENT

TREATMENT OR PROCEDURES - The consents provided by me/the Patient in this form also applies to all outpatient services provided to the Patient for the duration of such outpatient treatment as deemed necessary by the Patient's physician or treatment provider up to ONE (1) year.

K. FINANCIAL AUTHORIZATION: ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Rockdale Medical Center, Inc. ("Rockdale"), Radiology Physicians, Emergency Physicians, Anesthesia Services, Pathologists, Hospitalist, my attending physician and/or physicians associate with him/her and/or any other individual or entity whom he/she may designate. I further agree that any overpayment on this account resulting from collection from insurance companies (not having coordination of benefits) or other parties may be applied to any delinquent or outstanding accounts owed by me to Rockdale. I understand that I am financially responsible for non-covered services, and any deductibles, co-insurance or amounts greater than insurance benefits. I permit a copy of this authorization to be used in place of the original. I understand that the physicians groups for Radiology Services, Emergency Services, Anesthesia Services, Pathologists, and Hospitalist provide separate services from Rockdale and that I will be billed separately for services performed by them if treatment and/or evaluation is rendered. I understand that services deemed non-emergent by my insurance company and result in a denied payment will be billed directly to me and I will become responsible for payment in full.

I agree, whether I am signing as an agent or as the patient, that in consideration of the services to be rendered to the patient, or myself hereby individually obligates myself to promptly pay the account of Rockdale and physicians in accord with regular rates and terms of the Hospital and physician services. Bills are payable in full before the patient or myself leaves Rockdale. Provisional credit may be allowed for confirmed insurance payments due when assigned to Rockdale. All such provisional credits are subject to collections thereof by Rockdale. I understand that Rockdale and physician services are rendered and charged to the patient and not to the insurance company. **Rockdale and your physician cannot accept total responsibility for collecting your claim or negotiating a disputed settlement.**

L. FOR MEDICARE BENEFICIARIES ONLY

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holders of medical or other information about me to release to the Social Security Administration and/or Medicare Program or its intermediary carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

I/THE PATIENT OR AUTHORIZED REPRESENTATIVE OF THE PATIENT UNDERSTAND THAT THIS CONSENT AND RELEASE SHOULD BE READ BEFORE SIGNING, AND HAVE READ AND UNDERSTAND THIS DOCUMENT. I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THEY HAVE BEEN ANSWERED AND EXPLAINED TO ME IN A SATISFACTORY MANNER. **The undersigned, if other than the patient, and the patient are responsible for and agree to pay charges not covered by this assignment, including any Medicare deductibles.**

Signature of Patient or authorized representative

Guarantor signature if appropriate

Print Full Name of above Signature

Relationship to Patient

Witness:

DATE _____ Time _____ A.M. P.M.

CERTIFICATION OF CONSENT WITH USE OF INTERPRETER

I, the undersigned, certify that I have accurately and clearly interpreted and conveyed to the person signing on behalf of the patient all of the contents of this Consent Form. The person signing on behalf of the patient understood the contents of the Form, and all of his/her questions were answered.

Signature of Interpreter

Print above Signature

