Atlantic Health System | CentraState Healthcare System — Atlantic Health System Partner

DT7013

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, INCLUDING ADMISSION AND MEDICAL TREATMENT AUTHORIZATION

This form cannot be modified. Any handwritten changes to this form shall not be legally binding or enforceable.

GENERAL CONSENT, AUTHORIZATION, PATIENT RIGHTS AND RESPONSIBILITIES, PATIENT CONTACT

I authorize Atlantic Health System (which includes CentraState, Chilton, Hackettstown, Morristown, Newton and Overlook Medical Centers, collectively referred to as "Hospital"), Atlantic Medical Group ("AMG"), Atlantic Affiliates, Hospital staff, AMG staff and the physician(s) participating in my care to render hospital and medical care for my condition, which may include routine diagnostic procedures and such other medical treatment as may be deemed advisable by the physician(s) participating in my care. This may or may not include admission to the Hospital. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand and acknowledge that the majority of the physicians at the Hospital are members of the Voluntary Medical Staff and are not employees or agents of the Hospital, but are either independent contractors or independent practitioners who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. This includes, but is not limited to, Emergency Department physicians, anesthesiologists, cardiologists, neonatologists, obstetricians, pathologists, radiologists, surgeons, the on call physician, telehealth providers, and other consultants who may treat me. I understand that telehealth involves the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services. I consent to treatment and care by Hospital affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through telehealth. I understand that physicians in training, medical and nursing students, and paramedical personnel may observe and participate in my care under the supervision of the Hospital or AMG staff and my physician(s). I authorize the Hospital to arrange for the disposition of all specimens and tissues. These consents and authorizations shall also apply to the admission and medical treatment of a newborn infant who is delivered by me during my hospitalization. I understand that it may be necessary for my healthcare provider(s) to take photographs, films, recordings and/or other like images and that the presence of a vendor representative may be required for medical, educational and/or continuity of care purposes.

☐ **I hereby acknowledge receipt of a Statement of Patient Rights and Responsibilities.** I understand that professional personnel are available to explain the Statement upon request.

The Hospital maintains a current list of patients and their location in the hospital. ☐ **I hereby permit my location to be provided to friends, family and/or visitors.**

I authorize Hospital, AMG and Atlantic Affiliates, all clinical providers who have provided care to me, and their authorized agents, including but not limited to any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me via electronic mail, text and/or telephone on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology. ☐ **I hereby authorize such contact at this time.**

FINANCIAL ARRANGEMENTS

I understand the Hospital charges do not include the fees of my treating physician or the fees for services provided by other Voluntary Medical Staff who may treat me. I understand that I am financially responsible for the payment of my physician fees and my hospital bill; these fees may not be covered by my insurance plan. I authorize payment of medical insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to the Hospital and/or any physician(s) participating in my care. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries, and it may be my responsibility to obtain appropriate pre-approvals. If I am receiving hospital billed services, a copy of "An Important Message from Medicare" or "An Important Message from TRICARE", as applicable, and "Notice of Charity Care and Reduced Charge Charity Care" have been made available to me. I understand my rights as outlined in the document(s) I have received. A deposit may be requested. If I am a Medicaid beneficiary, I certify that I am receiving the services covered by this consent and I request that payment for these services be made. **Not applicable to Emergency Department Treatment Authorization.**

PROTECTED HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). The Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI"). I have had an opportunity to review this information before signing this form. I consent to the Hospital, Atlantic Affiliates, AMG and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) in order to carry out treatment, payment, or health care operations. This includes any medical information (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV related information including HIV testing results (if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to this hospitalization (including precertification or verification, if necessary), or which may be needed to conduct continued care planning, which may include release of my PHI to home healthcare agencies.

AUTHORIZATION TO DRAW BLOOD

In the event that any individual participating in my care is accidentally exposed to my blood or bodily fluids, I authorize the Hospital to draw my blood and test it for the presence of blood borne pathogens such as the Human Immunodeficiency Virus ("HIV"). I understand that if such testing is necessary the Hospital or my physician will make all reasonable efforts to notify me. I consent to the confidential disclosure of the test results to the authorized medical provider treating the person who has been exposed to my blood or bodily fluids, so that appropriate treatment determinations may be made. I understand that I do not have to agree to testing and/or disclosure of my test results.

____ **By initialing here I agree to be tested for blood borne pathogens such as the Human Immunodeficiency Virus ("HIV") and I consent to the disclosure of my blood test results.**

VALUABLES

I understand that the Hospital recommends all personal belongings and valuables be sent home with a family member or friend. I assume all risk for loss or damage to any personal belongings retained by me. The Hospital will not replace or reimburse me for any personal belongings which are lost, broken or stolen during my admission.

OUTPATIENT SERVICES IN HOSPITAL SETTING

I understand that I am having care, testing, procedure(s) or treatment that is considered an outpatient procedure in a hospital setting. As such, there may be different requirements for deductibles and/or copays than for a physician office visit. I understand that it is my responsibility to fully understand the requirements of my insurance company or managed care entity and that I am responsible for payment of any copayments, deductibles, and charges as required. If the services rendered qualify me for recurring status, my signature on this consent shall be valid for care rendered throughout this period.

_____ ***(Initial) I understand that there will be two components to my bill: the professional services provided by my physician and the tests and/or procedures conducted by the Hospital.***

_____ _____ _____ (am) (pm)

SIGNATURE OF PATIENT OR PERSON SIGNING / CONSENTING ON BEHALF OF PATIENT — Date — Time

If I am signing / consenting on behalf of the patient, I recognize that signing / consenting on behalf of the patient is not an acceptance of financial responsibility which I would not otherwise have for the services rendered.

_____ _____

PRINTED NAME OF PERSON SIGNING/CONSENTING ON BEHALF OF PATIENT — Relationship

For verbal consents, print full name of employee witness: _____ _____ _____ (am) (pm)

Date — Time

For verbal consents, print full name of employee witness: _____ _____ _____ (am) (pm)

Date — Time

PATIENT UNABLE TO SIGN BECAUSE: _____