

CONSENT FOR TREATMENT: I request and consent to care and treatment as my physician considers necessary. I authorize the performance of diagnostic tests, lab tests, X-rays, and other medical or surgical procedures recommended by my physician. I consent to admission to Saint Mary's Health Care (SMHC) and to permit my admitting physician, or designee physicians who may be consulted regarding my treatment, as well as nurses, resident, technicians, students, to provide the necessary care and services to me. I consent to photographing and videotaping of procedure(s) to be performed, for medical, scientific, or educational purposes as well as for the purposes of identification. I understand these will be stored in a secure manner that will protect my privacy. Images that identify me will only be released when authorized by me or as needed to provide for my continued medical treatment or identification. I understand that if an employee, physician, or affiliate of SMHC becomes contaminated with my blood or body fluids through any type of exposure, that I may be tested for the Hepatitis Virus and/or the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS).

NO GUARANTEE OR PROMISE OF RESULTS AND SMHC'S RIGHT TO DISCHARGE: I understand the practice of medicine is not an exact science. I acknowledge that no one has or can give me a promise or guarantee of what the results of my medical treatment and care will be. I understand that my admission and continued hospitalization is based upon my physician's determination of my need for the services and treatment. When my attending physician decides I no longer require hospital care and may be discharged, I will cooperate and arrange for discharge from SMHC. Further, I agree that nothing in this understanding prevents SMHC from discharging me immediately if I violate SMHC policies.

PHYSICAL ENVIRONMENT AND PERSONAL BELONGINGS: I recognize the SMHC has a right to search my person or my belongings at any time for the safety and protection of myself and other persons at SMHC. I understand that no one may have or bring into SMHC any illegal drugs or alcoholic beverages, toxic substances, dangerous articles or weapons of any type. If brought to the SMHC, I know the items will be confiscated. I understand SMHC is not responsible for any loss or damage of my personal property, or valuables.

ASSIGNMENT OF INSURANCE BENEFITS: Payment of insurance benefits (including Medicare or Medicaid) will be made directly to SMHC. I understand that I am financially responsible to SMHC and attending physicians for services in all circumstances such as: a) I am a managed care participant where prior approval is necessary by my primary care physician and or the managed care organization for payment; b) I have a worker compensation injury where prior approval is necessary by my employer for payment. This includes claims authorized today and later held in litigation by me or my employer; c) I am a participant of a non-contracted insurance carrier where SMHC is under no duty or obligation to seek payment before requesting full or partial payment from me; d) I am not covered by insurance and or the services provided by SMHC are not covered by my insurance carrier which includes co-payments and deductibles. I understand I will receive Physician billing separate from the hospital bill, as some Physicians are not SMHC employees, but provide services at SMHC.

RELEASE OF INFORMATION: I understand SMHC and any physician who treats me while I am a patient at SMHC can release necessary information to the responsible person or organization, which SMHC reasonably believes may be responsible for the payment of my hospital bill. I also understand that information relating to drug or alcohol abuse, psychiatric treatment, HIV/AIDS may be released to parties responsible for payment of my Hospital bills. If I am transferred to another facility, copies of my medical records will be released for continued care. I also agree SMHC may release my social security number, if applicable, to manufacturers for the purpose of tracking implanted medical devices.

PERMITTED USE OF PROTECTED HEALTH INFORMATION
PHI is information that could be used to potentially identify an individual and their related health information.

Should SMHC supply your protected health information for: 1) The hospital directory, so that your family, friends or members of the clergy can visit you while you are in the hospital if they ask for you by name. 2) Family or friends involved in your medical care. 3) Disaster relief purposes or for responding to and notifying your family in an emergency situation. You may agree or object to these uses of your protected health information.

Check the box that applies:

I AGREE to the use or disclosure of my protected health information as described above.

I OBJECT to the use or disclosure of my protected health information in the following situation(s):

Facility Directory: Individuals who inquire about me will be told that Saint Mary's has no information about me.

Family or friends: Only the following people may be given information about my care or payment arrangements.
(First name, last name and relationship)

Disaster Relief: My location, condition, or death will NOT be released to disaster relief agencies for the purpose of notifying my family. Saint Mary's will honor this request to the extent that it does not interfere with the ability to respond to emergency situations.

SMOKE FREE CAMPUS: I am aware that use of tobacco products on SMHC property or properties maintained by SMHC is prohibited.

THIS INFORMATION HAS BEEN PROVIDED TO ME AND BY SIGNING THIS FORM I AM BOUND BY WHAT IT SAYS, WHETHER I AM THE PATIENT OR SOMEONE ACTING ON THE PATIENT'S BEHALF. THIS CONSENT IS VALID UNTIL THE ACCOUNT IS RESOLVED.

X

Signature of Patient or other person acting on Patient's behalf

Date

Relationship to Patient, if signed by a person acting on Patient's behalf

Witness to Signature

Date



RELEASE FROM RESPONSIBILITY FOR DISCHARGE

This is to certify that I, _____,
patient at Saint Mary's Health Care acknowledge that I have been informed of the risks involved,
and hereby release the attending physician and hospital from all responsibility for any ill effect
that may result.

Signature of Patient or Legal Representative

Date

Person Signing (*please print*)

Witness