

Outpatient Admission Consent Form

Client Information Label

CONSENT TO TREATMENT:

I or my representative understands my admission to Cardinal Hill Healthcare System (CHHS) and my treatment at CHHS is indicated because of my condition. I voluntarily authorize and consent to the customary examinations, tests, procedures and emergency treatment performed on patients in my condition by hospitals/healthcare centers and to the medical treatment ordered by my physician(s).

I or my representative consent to be tested for HIV (the virus that causes AIDS), hepatitis or any other bloodborne infectious disease, for diagnosis or other purposes directly related to medical treatment if so ordered by my physician(s). If a health care worker is exposed to my blood or body fluids, CHHS may at its cost test my blood for any infectious disease. CHHS shall maintain confidentiality to the extent provided by applicable law: a) the fact that a blood test is ordered and, b) the results of such tests.

DISCLOSURE OF HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS:

I or my representative authorizes Cardinal Hill Healthcare System to release a summary of my care to any medical institution or physician responsible for the care subsequent to my discharge from the CHHS.

I or my representative authorizes payment of my insurance benefits to CHHS and the Physicians named on my insurance claim form. I further authorize release of information required by any third-party payer regarding any claim made relating to me. A copy of this form can be used in place of the original. I understand that I am financially responsible for charges not paid by my insurance company within 30 days after billing.

For and in consideration of hospital/healthcare center services provided, I or my representative assign and direct payment of my hospital bill from any amount due to me on my behalf from any person, corporation, insurance carrier, or from any settlement of judgment in any civil action.

MEDICARE PATIENTS ONLY:

I or my representative certifies that the information I have given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release that information to the Social Security Administration, the Medicare Program or their intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

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PHYSICIAN AND/OR OUTSIDE SERVICE PROVIDER STATUS:

I or my representative understands that certain physicians or outside service providers, (i.e. surgeons, physiatrists, radiologists, pathologists, prosthetists, DME venders, etc.) who may render care or services are independent contractors and are not employees or agents of CHHS. I understand I will be billed separately for the services of all physicians and/or outside providers. These charges are established by the physicians or outside providers.

The undersigned agrees that the provisions regarding the release of information and assignment of benefits stated in the previous section shall apply to the hospital/healthcare centers, and to such professionals and suppliers of services, or any of them, and their claims for payment. The undersigned further agrees that the execution of this document does not in any way imply that CHHS is responsible nor assumes any liability arising for the activities of any such professionals or suppliers of services.

HOSPITAL/HEALTHCARE CENTER IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ARTICLES:

I or my representative understands that CHHS will not be responsible for the loss of any cash, credit cards, personal items, valuables, etc., during therapy. CHHS is not responsible for anything left overnight (i.e. swimsuits, personal items, etc.)

PEDIATRIC PATIENTS UNDER 18 YEARS OF AGE ONLY: PARENT OR GUARDIAN REMAINING ON THE PREMISES:

I or my representative understands that I must remain on the premises during the time my child is in therapy, unless excused by the therapist.

NOTICE OF PRIVACY PRACTICES

We are legally required to provide you with a copy of our notice of privacy practices the first time you receive
care at a CHHS facility. You should have a copy. If you want another copy, please request one from us.

Date	Signature of Client or person authorized to sign on behalf of clien
Date	Witness
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