Patient Name_____
Dob___/___/_____
Patient Name_____
Dob___/___/_____
Patient Name_____
Dob___/___/_____
Patient Name_____
Dob___/___/_____

University Hospitals

GENERAL CONSENT

SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Authorization for Treatment

[Patient/Patient's legal representative] agrees to permit authorized personnel of University Hospitals [the Hospital] to perform such diagnostic and therapeutic procedures that my treating physician(s) deem necessary for care. By signing below I agree to permit x-rays, laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians arising in my care. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and complications associated with such treatment or procedures and I have given my consent. I further understand that the Hospital is a teaching institution and that physicians, nurses and other healthcare personnel in training may assist, be present and participate in providing my care and that my medical records may be used for educational purposes.

I recognize and understand that the physicians, including, but not limited to emergency department physicians, who provide services at the Hospital, with the exception of residents, are independent practitioners and not employees or agents of the Hospital. The Hospital is not responsible for the acts or omissions of physicians who are not directly controlled by the Hospital.

Authorization to Release Information

The undersigned hereby permits University Hospitals, the Hospital, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate health care insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in health care, participants in the Clinisync or other health information exchange(s), and/or the Hospital's agent(s), attorney(s) and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and health care operations including improving patient care, training or educating students, performance improvement initiatives, discharge planning, risk management, personal health record or other system-wide program(s) designed to foster interaction with patients via electronic means, and/or as required by law.

Assignment of Benefits

In consideration of the Hospital's and/or physician(s)' services received or to be received for medical/surgical services, I assign to the Hospital and/or my physician(s), all benefits herein specified, not to exceed the above hospital/physician(s) charges. I direct such insurer(s) to pay such benefits directly to the Hospital and/or my physician(s). I hereby agree to pay any and all hospital and/or physician(s) fees that exceed or that are not covered by my insurance coverage including services deemed to be experimental or investigational, and waive any and all notices and demands in the event of non-payment.

Medicare/TRICARE/Champus Payment/Notice Of Privacy Practices

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Acknowledgments

PLEASE CHECK THE APPROPRIATE BOX:	Yes	No	N/A
1. I acknowledge that if I am a Medicare and/or Champus/Tricare Beneficiary, I have been provided with a copy of the notice from Medicare and/or Champus/Tricare regarding my rights as a Medicare and/or Champus patient and that the form has not been altered.	☐	☐	☐
2. I agree to release my Social Security number to the manufacturer of any medical device that I may receive, in accordance with both federal law and regulations. I further understand that my Social Security number may be used by the manufacturer to help locate me if there is a need to contact me regarding my use of a medical device. I release the Hospital from any liability that might result from the disclosure of this information.	☐	☐	☐
3. I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP").	☐	☐	☐

If no, reason acknowledgment of NOPP not received:_____