Hendricks Regional Health

AUTHORIZATION AND PERMISSION FOR IMMUNIZATION

1. **MEDICAL AND SURGICAL CONSENT:** I request and authorize my doctor(s) and other doctor(s) who may attend me during this Emergency Services Department visit, Ambulatory Care Services visit or Hospitalization (hereinafter all referred to as "Medical Treatment"), their associates, assistants, and Hendricks Regional Health, its agents, employees, and students of affiliated health care training and/or education programs, (hereinafter referred to as the "Hospital"), to provide and perform such medical and surgical care, tests, drugs, procedures, other services and supplies as are considered advisable for my health and well being. This may include sedation/anesthesia, pathology, radiology, emergency services, other special services and tests ordered by a doctor. I also consent to the administration of sedation/anesthesia, as medically indicated, by a qualified doctor or person operating under the supervision of a qualified doctor. The administration of sedation/anesthesia may involve certain risks including reactions to medications, which could, on rare occasions, result in death. May also involve dental risks including chipped teeth or dislodgement. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to or relied upon by me. I authorize Hendricks Regional Health to dispose of any tissues or parts in accordance with its customary practice. For procedures such as surgery that are planned (not urgent or emergent), I will have the chance to review the risks and benefits with my doctor before giving consent. In urgent or emergent situations, I understand that it may not be possible to have a full and complete discussion prior to the procedure. In the unlikely event that a hospital employee, member of the medical staff, or contracted worker or student is accidentally or intentionally exposed to my blood or other potentially infectious body fluids, I consent to testing for bloodborne diseases. These diseases include, but are not limited to, hepatitis and human immunodeficiency virus (HIV, the virus that causes AIDS). I understand that the results of these tests will become a permanent part of my confidential record and will be utilized in counseling the exposed individual regarding his/her risk of developing a disease after the exposure. I will not be charged for these tests if related to an accidental or unintentional exposure.

2a. **RELEASE OF INFORMATION/JOINT NOTICE OF PRIVACY PRACTICES:** I further request and authorize the Hospital, its Doctors, all Independent Contracting Doctors and Doctors Groups (hereinafter all referred to as "Medical Care Providers"), to release to my insurance carrier or third party payers a copy of my medical records in connection with Workmen's Compensation, to release my medical records to others responsible for insurance claims and investigations. I further certify that the information given by me if applying for payment under Title XVIII (Medicare) and/or Title XIX (Medicaid) of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized benefits be made on my behalf. Upon this visit or admission, the Hospital will provide (for other than Mental Health Unit patients) via telephone at information center, my name, room number, telephone number, and condition. I hereby release all Medical Care Providers from all legal liability that may arise from the release of such information. I permit a copy of this authorization to be used in place of the original. I was offered a copy of the HRH Joint Notice of Privacy Practices.

2b. **AUTHORIZATION TO RELEASE INFORMATION FOR UTILIZATION REVIEW PURPOSES:** I authorize the Hospital to release information during and/or post-hospitalization when necessary or requested to my insurance carrier or their authorized agent.

2c. **PATIENT ASSIGNMENT BOARD:** I authorize the hospital to display in public view my name, room number and doctor, for purposes of room and staff assignments.

3a. **AUTHORIZATION FOR USE OF SIDERAILS FOR ACCESS TO PATIENT SERVICES:** I authorize the hospital to use one or two upper bed side rails so I may have access to needed patient services i.e., nurse call light, television & light controls, telephone and bed adjustment controls.

3b. **AUTHORIZATION FOR USE OF RESTRAINTS:** I authorize the hospital to utilize restraints, if needed to protect myself and others from harm.

4. **PERSONAL VALUABLES:** Money, jewelry and other similar valuables may be deposited for safekeeping. Articles of clothing, blankets, purse or other personal property brought with me but not required in the hospital should be taken home. I acknowledge that money, jewelry (watches, rings, bracelets, etc.), and similar property (such as eyeglasses, hearing aids, and dentures), unless deposited for safekeeping, and all other personal property including but not limited to clothing, blankets, radios, and purse are kept at my own risk, and the Hospital is not liable in the event of loss, or damage. NO HOSPITAL EMPLOYEE HAS THE AUTHORITY TO WAIVE THIS RULE.

5. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby authorize all Medical Care Providers to directly collect all Insurance Plan and/or Employee Health Plan benefits to which I would be entitled as a result of this Medical Treatment.

6a. **GUARANTEE OF ACCOUNT:** I understand I am financially responsible to all Medical Care Providers for the charges billed for services rendered during this Medical Treatment which are not covered by my Insurance Plan or Employee Health Plan. If my Plan requires prior authorization for any services and I fail to obtain this authorization, my insurance carrier may apply a penalty fee, which is my financial responsibility. I hereby agree to pay all Medical Care Providers for all services rendered during this Medical Treatment. I shall also be responsible for all reasonable costs of collection of this account including but not limited to collection agency fees, attorney fees and court costs.

7. **AUTHORIZATION TO RECEIVE TELEPHONE AND OTHE ELECTRONIC COMMUNICATIONS:** I authorize the Hospital, the Hospital's affiliates and subsidiaries and the Hospital's agents, along with any billing services, collections agencies, attorneys or other agents who may work on their behalf, to contact me on my residential and /or wireless telephone using pre-recorded messages, artificial voice messages, automatic telephone dialing systems, or other computer assisted technology, or by text message, electronic mail, or any other form of electronic communication.

8. **I consent to treatment for this admission or for repeat treatments from _____ through _____ or _____ number of treatments.**

9. **I certify I am the custodial parent and/or legal guardian of the student with authority to consent to his/her health care and hereby consent to their receipt of the immunization as described in the accompanying documentation.**

_____ _____

Parent/Guardian Signature Date/Time Patient Signature Date/Time

_____ Patient's Date of Birth ____/____/____ Insurance

Reason Patient Unable To Sign Subscriber's Date of Birth ____/____/____

χονγεν