ORANGE REGIONAL MEDICAL CENTER

Office Use Only

CONSENT

Admission and Treatment

I consent to admission and the rendering of care at Orange Regional Medical Center that may include routine diagnostic procedures and such medical treatment directed by my attending physician or other of the hospital medical staff considered to be necessary. I understand that photographs, videotapes, or digital or other images may be recorded to document care.

I realize that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as the result of the examination or treatment of this hospital. I understand that:

a. Unless there is an emergency or other extraordinary circumstances exist, no invasive procedures are performed upon a patient unless, and until, he/she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction.
b. Each patient has the right to consent or to refuse consent to the proposed procedure or therapeutic course.
c. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent.

I understand that many of the physicians on the staff of this hospital, including the attending physician(s) named, are not employees or agents of the hospital, but rather are independent practitioners who have been granted the privilege of using its facility for the care and treatment of their patients. Further, I realize that among those who attend patients at this hospital are medical, nursing, and other healthcare personnel in training who, unless requested otherwise, may be present during patient care as a part of their education.

<u>If registered as an inpatient</u>**,** I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare/Champus", information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient), with information about how I can exercise the right explained in these materials. If I have any concerns regarding any care, including ethical issues, I can request a consultation with the hospitals' Case Consult Team. I can ask my physicians or nurses for more information.

I understand that the hospital staff, as well as the physician who are associated with the hospital, operating under an organizational code of ethical behavior. All clinical decisions related to my health care will be based upon my health needs. I understand that I have the right to know the name of my physician who has primary responsibility for my care and the identity and professional status of individuals responsible for authorizing and performing procedures or treatments on me. I know that I will be informed of any professional relationships that the hospital/physician have to another health care provider/institution involved in my care that might suggest a conflict of interest, including business relationships and relationships with educational institutions. Any policies, procedures related to information on the hospital's organizational code of ethical behavior will be made available to me upon my request. I understand that I can notify my nurse, the hospital administration, or my physician with questions or concerns that I have regarding the above information.

Personal Belongings

<u>I understand that ORMC is not responsible for safeguarding personal possessions retained at my bedside.</u>

ASSIGNMENT OF BENEFITS
In consideration of services and treatment rendered, I hereby assign, transfer, and set over to Orange Regional Medical center all health insurance, worker's compensation, and automobile benefits of any nature whatsoever now due and due to become due and payable to me, including personal injury protection, medical payments, underinsured/uninsured benefits, any benefits of any other coverage which becomes available to me for hospital and physician services. I hereby direct all above third party payers to pay such benefits directly to Orange Regional Medical Center in consideration of services furnished and to be furnished by Orange Regional Medical Center and its physicians.

I understand that the charges of all physicians involved in the diagnosis and treatment of my care are separate from the hospital charges. *I understand that I am financially responsible to the hospital and those physicians for charges not covered or paid by my insurer and that some of those physicians may not participate in my insurance plan.*

RELEASE OF INFORMATION
Authorization is hereby granted to release such information as may be necessary for my care and for the completion of my hospitalization claims via mail, electronic or facsimile transmission. I understand that medical information, while adhering to rules and regulations, will be disclosed to any organization responsible for reimbursement or provision of care/services. Orange Regional Medical Center shall provide copies of my medical records containing diagnostic information and test results (including legally protected data related to sexually transmitted disease, AIDS, psychiatric care, substance abuse care, and social services) to any physician or facility (a) for the purpose of facilitating the transfer or referral of my care (b) when I have consented to the transfer or referral of my care to such physician or health care facility and to my referring/family doctor as appropriate. I hereby release the above named facility from all legal liability that may arise from the release of the information requested.

NOTICE OF PRIVACY PRACTICES (Excludes Referred Outpatient Non-Invasive Procedures, for example Lab tests or Diagnostic Imaging tests ordered by your physician).
By signing below, I acknowledge receipt of The Notice of Privacy Practices, wh8ich outlines how health information about me may be used or disclosed.

GUARANTEE OF PAYMENT FOR NON-COVERED CHARGES
For and in consideration of services rendered or to be rendered to the above named patient by ORMC and/or its Hospital Based Physicians during the admission commencing on or the visit on the above refereed date. I/we hereby guarantee payment, jointly and severally, of any and all charges incurred by the above-named patient for which the hospital has not been reimbursed by an insurance company or government agency. I/we understand that all bills are due upon presentation and that in the event I/we default in fulfilling the terms of this agreement, I/we agree to pay, in addition to the amount owing on this account, any reasonable attorney's fees incurred in the collection of the account. In the event that the above named patient is admitted on the above referenced admission date for delivery of a newborn child(ren), this guarantee of payment shall also apply to any charges incurred by said newborn(s).

This form has been explained to me and I am satisfied that I understand its contents and significance. I permit a copy of this Authorization to be used in place of the original.

Patient's Signature: ________________________________ *Date:* _________

Witness (must be an adult)*:* __________________________ *Date:* _________

*If the patient is incapable of signing and another person signs in his/her stead, please complete why the patient is unable to give consent personally or acknowledge receipt of Notice of Privacy Practice and unable to sign this form:

- ☐ Minor (any unmarried male or female who has not reached his/her 18th birthday)
- ☐ Unconscious
- ☐ Physical condition
- ☐ Mentally incompetent
- ☐ Other ____

Relationship of signer to patient: __________________________