Hospital-wide
Consent for Admission and Treatment

1. **PATIENT BILL OF RIGHTS:** The undersigned acknowledges having received a copy of the Bill of Rights. **INITIAL HERE _____.**

2. **GENERAL DUTY NURSING:** The Hospital provides only general duty nursing care. Under this system nurses are called to the bedside of patients by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by the patient or his/her legal representative, or his/her physician, and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. **MEDICAL & SURGICAL CONSENT:** I hereby authorize the physician and OCH Regional Medical Center to administer any treatment, medication and consent to any surgical treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient or me. This consent will expire automatically 180 days from the date shown below or upon the patient's discharge from the Hospital. I understand that the Hospital may wish to take photographs or films during the course of my treatment to be made part of the medical record to document condition of site and/or care rendered.

4. **PATHOLOGIST SERVICES:** I hereby authorize the Hospital to dispose of at their discretion any specimens or tissues taken from my body during my hospitalization. Further, it is understood and agreed that all tissue, cytology (Pap smear) and bone marrow specimens will be analyzed and professionally interpreted by a Board Certified Pathologist on the Medical Staff of the Hospital. **I UNDERSTAND I WILL RECEIVE TWO BILLS FOR THE PATHOLOGY EXAMS, ONE FROM THE HOSPITAL AND ONE FROM THE PATHOLOGIST FOR HIS PROFESSIONAL SERVICES.**

5. **RADIOLOGIST SERVICES:** It is understood that all x-ray procedures at this Hospital are read by a qualified radiologist. A radiologist is a doctor who specializes in reading x-rays. **I UNDERSTAND I WILL RECEIVE TWO BILLS FOR X-RAYS, ONE FROM THE HOSPITAL FOR THE ACTUAL TEST(S) AND ONE FROM THE RADIOLOGIST FOR HIS PROFESSIONAL SERVICES.** After the date of service, I authorize the destruction of all x-ray film and other graphic data in accordance with all state and federal laws which control the storage and retention of such data.

6. **SURGERY / ANESTHESIOLOGY: I UNDERSTAND I WILL RECEIVE TWO BILLS FOR SURGERY, ONE FROM THE HOSPITAL AND ONE FROM OCH PROFESSIONAL SERVICES FOR FEES RELATED TO ANESTHESIOLOGY AND CRNA SERVICES.**

7. **RELEASE OF INFORMATION:** Authorization is hereby granted to OCH Regional Medical Center and/or all physicians providing treatment, diagnostic testing, interpreting x-rays, or reading E.K.G.'s to release such information as may be necessary for the completion of my insurance claims for services rendered during my hospitalization. A copy shall serve as original. Original signature shall be on file at OCH Regional Medical Center. Should my insurance company require an admission diagnosis for precertification and should clinical information for my continuous stay be required, authorization is hereby granted to release said information.

8. **PERSONAL VALUABLES:** It is understood and agreed that the Hospital maintains a safe for the safekeeping of money and valuables and the Hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents or other articles of unusual value, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping.

9. **ASSIGNMENT OF INDIVIDUAL BENEFITS:** In the event the undersigned is entitled to hospital or surgical benefits of any type whatsoever arising out of any policy of insurance, said benefits are hereby assigned to OCH Regional Medical Center and all physicians providing services for application of the patient's bill, the undersigned and/or patient being responsible for charges not covered by this assignment. A copy shall serve as original. Original signature shall be on file at OCH Regional Medical Center.

10. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, he/she hereby individually obligates himself/herself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. I hereby authorize OCH Regional Medical Center to apply at its discretion any credit balance which may show on this account as a result of any payments by me, my representatives, or any third party payer, to any and all other open accounts, for which I/we may be responsible. Should the account be referred to an attorney for collection, a collection agency, or through a civil action in justice or circuit court, the undersigned shall pay reasonable legal fees and collection expenses. The undersigned further agrees to pay an additional charge to the patient's account when the payer's check, in full or partial payment of the account, is returned for insufficient funds or on a closed account.

11. **NOTIFICATION BY PROVIDER OF MEDICARE/MEDICAID & MANAGED CARE NONCOVERED SERVICES:** I hereby acknowledge and understand before services are rendered that I, or my guarantor will be responsible, including but not limited to, for full payment of known or any non-covered charges, in whole or in part of a qualified Health Plan or Managed Care Network, such as self-administered medication in outpatient (i.e. observation ER or outpatient diagnostic) and any days of care not covered by Medicare and/or other third party payers and applicable deductible, coinsurance amounts and charge differential for rooms. Patients with Medicaid will be responsible for copayments, room differentials and any miscellaneous charges incurred such as cot, guest meals, etc. will be the responsibility of the member or guarantor before discharge.

12. **COMMUNICATION REGARDING MY ACCOUNTS:** Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

The undersigned certifies that he/she has read this foregoing, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

Patient _____ Date: _____ Time of signing: _____

Patient's Agent/Representative: _____ Relationship to Patient: _____ Date: _____

Patient is unable to sign/consent because_____

Witness: _____ Date: _____ Time of signing: _____