

## PATIENT AGREEMENT and CONSENT

As a condition of my or my child's admission or treatment to the Hospital/Facility I hereby agree to the following:

- 1. CONSENT TO TREATMENT:** I hereby authorize the physicians in charge of my care and the Hospital/Facility to provide services including, but not limited to, emergency medical services, routine diagnostic procedures, and medical procedures as their judgment may deem necessary or advisable. I understand that, under the direction of my treating Physician, a Physician's Assistant, Advanced Registered Nurse Practitioner, students or residents affiliated with the Hospital/Facility may be utilized in my care and treatment.
- 2. CONSENT TO TRANSFER TO 24 HOUR FACILITY:** I hereby consent to be transferred to a 24 hour facility for further medical treatment when my medical condition indicates that level of care is appropriate in the judgment of my treating physician.
- 3. LEGAL RELATIONSHIP BETWEEN HOSPITAL/FACILITY AND PHYSICIAN(S):** I acknowledge that any physicians and surgeons furnishing services to me including, but not limited to, radiologists, anesthesiologists, pathologists, and emergency room physicians are independent contractors with me and are not employees, agents or servants of the Hospital/Facility. I further understand that I am under the care and supervision of my attending physician(s). Further, I understand that it is my attending physician(s) sole responsibility to obtain my informed consent when required for medical, surgical, diagnostic, or therapeutic procedures, or hospital services rendered to me under the general or special instructions of my physician(s).
- 4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby authorize the Hospital/Facility and/or any treating physician(s) to release to any third party payor (such as an insurance company, its designated review agency or a government agency) only such diagnostic and therapeutic information (**including psychiatric, drug abuse, alcohol, or HIV status**) as may be necessary to determine benefits entitlement and to process payment claims for health care services provided to me, commencing on this date. The Hospital/Facility and any physician(s) rendering service at the Hospital/Facility are authorized to release information from my medical records to any skilled nursing facility or other health care facility to which I may be transferred for continuing care or research purposes.
- 5. MEDICARE/MEDIGAP/MEDICAID/PATIENT CERTIFICATION/RELEASE OF INFORMATION & PAYMENT REQUEST:**  
I certify that the information given to apply for payment under Title XVIII and/or Title XIX, of the Social Security Act 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. 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, Medigap or Medicaid for payment to me. I understand that I am responsible for any health insurance deductibles and co-payments.
- 6. ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize, request and direct any and all assigned insurance companies to pay directly to the Hospital/Facility and/or any treating physician(s) the amount due me in my pending claims for hospital/facility benefits under the respective policies. I agree that should the amount be insufficient to cover the entire Hospital/Facility expense, including the co-payment and the deductible, I will be responsible for payment of the difference, and that if the nature of the services rendered are not covered by said policy, I will be responsible to the Hospital/Facility and/or any treating physician for payment of the entire bill.
- 7. AGREEMENT TO PAY FOR THE PROFESSIONAL COMPONENT OF PATHOLOGY SERVICES:**  
I understand that testing of my laboratory specimens such as blood, urine, stool or similar material while I am in the hospital is performed under the supervision of the pathologists who direct the laboratory. Although they may not personally perform the test or review the results, the pathologists are responsible for supervising the laboratory to assure clear, timely, and clinically reliable reporting of my tests to my doctor, assure compliance with regulatory standards and are available to address questions from the laboratory staff or my doctor. The pathologists may bill me a professional fee whether these services are direct or indirect as described above. I accept responsibility for payment of these charges to the extent they are not paid for by my insurer or managed care plan.

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8. **GUARANTEE OF PAYMENT:** For value received, including but not limited to the services rendered, I agree to guarantee and promise to pay the Hospital/Facility and/or any treating physician(s), all charges and expenses incurred in my treatment, including those expenses not covered by any insurance policy presently in force, including any co-payment and/or deductible. Unless specifically agreed in writing, all charges shall be paid at discharge. Unpaid accounts shall bear interest at the rate provided by law, whether suit is brought or appeal taken. If any action at law or in equity is brought to enforce this agreement, the Hospital/Facility and/or any treating physician(s) shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.

9. **RELEASE OF RESPONSIBILITY AND LIABILITY FOR PERSONAL VALUABLES:** I understand and agree that the Hospital/Facility is not responsible for personal valuables or belongings brought into the health system, or claimed to have been brought into the health system by me or my agent. Personal valuables or belongings include, but are not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices (such as hearing aides, artificial limbs, or assist devices such as: canes, walkers, or wheelchairs), credit cards, jewelry and money. I understand that the Hospital/Facility discourages retaining personal valuables at bedside and that a locked area is available for securing my personal valuables small enough to fit in a security envelope. **Valuables not claimed within 90 days of discharge will be discarded.**

10. **RECEIPT OF "AN IMPORTANT MESSAGE FROM MEDICARE/ CHAMPUS":** I understand that after my discharge from the Hospital/Facility, an individual from the State of Florida's Peer Review Organization (PRO) may review my records of care. I understand that the purpose of this review is to determine whether or not admission to the Hospital/Facility was necessary and to review the quality of care given to me during the time I was hospitalized. My signature only acknowledges my receipt of "An Important Message from Medicare" and does not waive any of my rights to request a review or make me liable for my payment.

11. **RECEIPT OF PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES BROCHURE AND NOTICE OF PRIVACY PRACTICES:** By my signature on this document, I acknowledge receipt of a Patient's Bill of Rights and Responsibilities brochure pursuant to Florida Statute 381.026, prior to or at the time of admission and the Notice of Privacy Practices.

12. **PRIVATE ROOM:** If I request a private room, I understand that the extra charge for the private room is my responsibility. I understand there is no guarantee that I will get a private room.

I request a private room:  No  Yes

13. **FACILITY DIRECTORY:**  I DO NOT want to be listed in the facility directory. I understand the facility will not direct visitors/callers to my room when they ask for me by name, clergy will not be given my information to visit me unless specifically consulted, and special deliveries will be sent back to the sender.

**OBSTETRICAL PATIENTS ONLY**

14. **RECEIPT OF NICA INFORMATION:** By my signature on this document, I acknowledge receipt of Neurologic Injury Compensation Act (NICA) information pursuant to Florida Statute Section 766.301, prior to or at the time of admission.

**I CERTIFY THAT THE INFORMATION CONTAINED IN THIS DOCUMENT HAS BEEN READ BY OR EXPLAINED TO ME AND I UNDERSTAND THIS INFORMATION. I WILL RECEIVE A COPY OF THIS DOCUMENT UPON REQUEST. I ACKNOWLEDGE THAT A COPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.**

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient unable to sign because \_\_\_\_\_

Signature of Patient's Authorized Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Hospital Representative (Witness) \_\_\_\_\_