LIFEBRIDGE HEALTH
CARE BRAVELY

ADMINISTRATIVE CONSENT

Bar Coded Patient Label

50061

CONSENT TO TREATMENT

I am presenting myself as a patient to a LifeBridge facility, practice, department, or office and I voluntarily consent to the rendering of such care and treatment as may be ordered by my physician, associate or assistant. This includes all medical treatments such as diagnostic studies that may require oral or intravenous contrast, laboratory tests, including HIV testing (if clinically indicated), and minor procedures my physician(s) may order.
I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments upon my condition.
I understand that COVID-19 is a contagious disease that can sometimes lead to hospitalization or death. I understand that while LifeBridge Health affiliated providers have put into place reasonable precautions to reduce the spread of COVID-19, carriers of the virus may not show symptoms and still be contagious. I understand that despite reasonable measures being taken, it is possible that I may become infected with COVID-19 while seeking, or as the result of receiving, treatment at a LifeBridge Health affiliated facility or office. I understand that COVID-19 may present additional risks not presently known. I understand that COVID-19 testing is not 100% accurate. I understand that I may defer treatment but have elected to receive treatment even though I am aware of possible risks

_____ (initials)

Further, I understand that many of the physicians on staff are not employees or agents of the hospital but, rather are independent contractors who may have been granted the privilege of using its facilities for the care and treatment of their patients. I realize that among those who attend patients at this hospital are medical, nursing and other health care personnel in training who, unless requested otherwise, may be present during patient care as a part of their education. I understand that if the employment status of an individual is important to me in making treatment and other decisions, I may inquire as to that individual's employment status.

_____(initials)

PATIENT RIGHTS

I understand that I have the right to consent or refuse consent to any proposed procedure or therapeutic course. I also understand that it is customary, absent emergency or extraordinary circumstances, that no procedures which pose a material risk or harm are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction.
No patient will be involved in any research procedure or experimental procedure without his or her full knowledge and consent. I acknowledge having seen or received a copy of the Patient Rights and Responsibilities and understand its contents.
I understand that LifeBridge Health personnel may photograph, videotape, or create other images of me for purposes related to treatment, payment, and health care operations. This includes photographs taken routinely to provide care and treatment. Additionally, I understand that these images may be used within LifeBridge Health to educate faculty, residents, and students involved in their educational programs.
I acknowledge that for my safety there may be areas of the hospital (including patient care areas) where video surveillance is taking place. I understand that LifeBridge Health, Inc., its affiliates and their employees will take necessary steps to protect my privacy.

PERSONAL BELONGINGS

I understand LifeBridge Health, Inc., its affiliates and their employees are not responsible for my personal belongings. I accept full responsibility for any items I retain in my possession.

_____(initials)

AUTHORIZATION

I hereby consent to the release from my medical records, complete medical information which may include test results, diagnosis and reports of treatment (the "Medical Information") in accordance with any statutes or regulations Some examples of required reporting include, but are not limited to: reporting of newly-diagnosed HIV cases, tuberculosis, viral meningitis, or other communicable/contagious diseases to the Health Department; reporting to previous health care facilities if there is a concern that I developed a complication while under their care; reporting to regulatory agencies in response to complaints; and for licensure and accreditation.

NOTICE TO OUR PATIENTS

I understand that if treated in physician's office that is in an outpatient department of one of the Hospitals I may receive two bills for appointments in the office. I understand that one bill is for the physician services and the other for an outpatient clinic bill from one of the Hospitals. Together the two bills will represent charges incurred during the visit. I understand I will incur a coinsurance liability to the hospital that I would not incur if the facility were not provider based.

AGREEMENT TO PAY FOR SERVICES

For and in consideration of services rendered or to be rendered to the aforementioned patient, I agree to pay LifeBridge Health, Inc., its affiliates, and any physician or physician group providing treatment or services to me in full for said services together with all collection costs and reasonable attorney fees if any.

AUTHORIZATION TO RECEIVE CALLS

I hereby authorize auto-dialed and/or pre-recorded message calls from LifeBridge Health, or its affiliates and their agents, to the contact numbers provided by me. This includes, without limitation, any third party debt collector.

RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII 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 authorize LifeBridge Health, Inc, its affiliates, and any physician or physician group treating or rendering service to me to release the information necessary for filing a claim with any insurance company, employer or group and authorize said insurance company, employer or group to pay directly to LifeBridge Health, Inc., its affiliates and any applicable physician or physician group the benefits otherwise payable to me but not to exceed the hospital's or physician's regular charges for this period of treatment. I irrevocably assign unto LifeBridge Health, Inc., its affiliates, and any physician or physician group treating me any and all health insurance proceeds payable to me for covered services herein.

SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE	DATE	TIME	PRINTED NAME AND RELATIONSHIP TO PATIENT
	DATE	TIME	ID#