

CONSENT FOR TREATMENT

I, knowing that I have a condition requiring diagnosis and medical or surgical treatment, do hereby consent to the following:

1. All medical and surgical treatment, x-ray, laboratory and other medical procedures as may be performed or prescribed by my physician or any person (including other physicians to be consulted, assistants and personnel) who may be designated. I acknowledge that Sanford Health conducts training programs in which students or practitioners in areas of health care learn under supervision and may be involved in my care. I further acknowledge that no guarantees have been made to me as a result of treatment or examination.

2. To testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

AUTHORIZATION OF BENEFITS

I consent to release of my medical information for payment purposes to health insurers or third party payers. I hereby authorize payment directly to the provider for insurance benefits otherwise payable to me, but not to exceed the balance due of the provider's regular charge. **I understand that I am financially responsible to the provider for charges not covered by this authorization.**

DISCLOSURE OF HEALTH INFORMATION

I consent to the disclosure of my health information to other healthcare professionals or entities for treatment purposes.

I agree to the sharing of medical information with my family, friends or others when it reasonably appears they are involved with my treatment, medical decisions or payment for my care.

If I do not agree, I will ask for a restriction request form.

FOR HOSPITAL USE ONLY:

RESPONSIBILITY FOR PRIVATE ROOM

For offering semi-private rooms:

I agree to accept financial responsibility for the cost of a private room.

YES NO N/A

RESPONSIBILITY FOR PERSONAL VALUABLES

I understand that I am responsible for my personal valuables (including money, jewelry, dentures, hearing aids, eyeglasses, etc.) while a patient here unless I ask to lock my personal items in a safe. **I hereby release this facility or any hospital employee from any liability from loss by theft or negligence of mine.**

I wish to deposit my valuables in the hospital safe: YES NO

MEDICARE PATIENTS ONLY

MEDICARE CONSENT. 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 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 the attending physician to submit a claim to Medicare for payment. **I hereby authorize the use of Medicare Lifetime Reserve Days Benefits as necessary for payment of charges.**

I certify that I understand and authorize the above information.

Patient Signature _____

Or/By _____

Relationship to Patient _____

Employee's Initials _____ Date _____

DISBURSEMENTS: ORIGINAL - CHART WHITE - PATIENT WHITE - ADMISSIONS

Consent for Treatment and Payment
6131324



PR6131324

Patient Name: _____

DOB: _____