Marshfield Clinic Health System

Location: _____

Patient Name: _____

MRN: _____ DOB: _____ Sex: _____

Consent Treatment

General consent: I understand that I may have a health problem requiring evaluation, diagnosis, treatment and/or hospitalization. I voluntarily consent to necessary routine medical assessment, treatment, general diagnostic procedures, radiologic procedures, and/or hospital care ordered by my provider or his/her assistant. I recognize that my care is directed by physicians or other health care practitioners, some of who are not employed by, but rather serving as agents of the facility. I understand that the facility is not liable for any act or omission of the instructions given by such physicians while I am in the facility. For Inpatient services only, I understand that video-surveillance (e.g. video-taping, video-monitoring) may be used for the purposes of patient care, treatment, and/or safety. If I am pregnant, I agree that all the provisions of this Treatment Consent also apply to my newborn child/children for their care and treatment while in the hospital after birth.

Directions and information: Each patient has the right to consent to or refuse any proposed procedure or therapeutic treatment. I understand I should tell the provider or nurse if there is anything I do not want performed. The provider is responsible for explaining the nature of my condition and treatment and the other ways that this condition could be treated, if any. He/She is responsible for explaining significant risks involved with the treatment, if any.

No guarantee of care: I understand that the provision of health care services is not an exact science. I acknowledge that no guarantees have been made to me as to the results of examinations or treatments to be provided to me in the facility.

Personal valuables: I understand that the facility maintains a safe for storage of patient valuables during hospitalization. I agree that the facility does not assume liability for any loss or damage to valuables not deposited in this safe.

Health care education: I understand that some Marshfield Clinic Health System facilities participate in health care education or training programs and agree that, at times, I may receive health care services performed, or observed, by students or trainees under appropriate supervision. I understand that I have the right to decide who participates in providing care to me and that I may decline participation of students or trainees in delivery of care to me.

Medical records: I understand that, upon written request and with reasonable notice, I may review and receive a copy of my medical record, at my own expense, or have my records transferred to another health care provider. I understand that review of my records shall take place in the Medical Records department during regular business hours. I also understand that I may authorize other persons to review and receive a copy of my medical record by signing a Release of Information Authorization which identifies my name, the purpose of the disclosure, the type of information to be disclosed, the individual, agency, or organization to which the records are to be disclosed, and the time period during which disclosure is permitted. All releases of information must comply with the HIPAA policies and procedures.

Correspondence/Communication:

- **Consent to Contact:** I consent to receive communications from Marshfield Clinic Health System, its contractors and collection representatives on any phone number I provide or later acquire (cell or landline). I may be contacted about an appointment, follow-up reminder, and assignment of benefits and/or financial responsibility. Contacts may be via live agent, voicemail, text message, auto dialer or other technology. I understand depending on my phone plan I may be charged for calls or text messages.I understand my consent to receive such calls or texts is not a condition of receiving healthcare services.I understand that unencrypted text-messaging is not secure and I accept the risk of loss of privacy through text-messaging.
- **Use of Phone:** I agree Marshfield Clinic Health System, its affiliates and agents may use an automated telephone dialing system, pre-recorded messages, and texting, to contact the wireless number(s) and/or residential lines I provide to Marshfield Clinic Health System for appointment and payment purposes.
- **Consent to Contact:** I consent to receive communications from Marshfield Clinic Health System, its contractors and collection representatives on any email address I provide or later acquire. I may be contacted about an appointment, follow-up reminder, and assignment of benefits and/or financial responsibility. I understand my consent to receive such emails is not a condition of receiving healthcare services. I understand that unencrypted emailing is not secure and I accept the risk of loss of privacy through emailing.

CNS

Additional copy to patient

Consent Treatment (Continued)

Patient Name:	MRN:	DOB:	Sex:

Assignment and financial agreement: In consideration for services rendered by the hospital, I irrevocably assign my insurance benefits directly to Marshfield Clinic Health System (MCHS) and I agree that these benefits otherwise payable to me shall be paid directly to MCHS. I understand that I am financially responsible to the facility and I agree to pay the facility all such charges that are not paid by my insurance plan, Medicare, Medicaid, PPO, HMO or other coverage, in addition to co-payments and deductibles. If the account is referred for collection, I agree to pay the costs of collection, including actual attorney's fees.

Release of information for billing purposes: I agree that the facility and all health care providers participating in my treatment may release to, and receive from my insurers, other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for the purpose of billing, collection or payment of claims for services provided to me.

Patient's certification/payment request under Title XVIII Social Security Act: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I assign payment of the unpaid charges for physician services to the physician or organization authorized to bill in connection with the services. If I am entitled to benefits under Title XVIII, I understand I am responsible for any health insurance deductible and coinsurance.

Notice of privacy practices acknowledgement: By signing this form, I acknowledge that the respective Marshfield Clinic Health System (MCHS) facility has provided me with a copy of the Notice of Privacy Practices. The Notice explains how my health information will be handled in various situations. If I have minor children (children under the age of 18) living with me, I also acknowledge by signing this form that I have received this Notice on their behalf. Marshfield Clinic Health System will make a good faith effort to obtain written acknowledgement of my receipt of the Notice upon my first date of service with this facility. If my first date of service at this facility was an emergency situation, Marshfield Clinic Health System will provide the Notice to me as soon as reasonably possible following the emergency situation.

Facility/Patient directory: In the event that I would be admitted to the hospital, I acknowledge that my name, location in the facility and general medical condition will be listed in the facility directory. The directory information will be provided to persons who ask for my information by my name. I understand that I must inform an employee if I object to this practice.

Patient rights and responsibility: I acknowledge that I have been notified of my patient rights and responsibilities, via written materials or posters in prominent locations. I am being informed that if a health care provider or employee is significantly exposed to my blood or body fluids, my blood may be tested for human immunodeficiency virus (HIV), the virus that causes AIDS. I agree to comply with all facility rules and regulations and with all patient responsibilities in the materials provided to me.

Follow-up responsibility: I understand that I may return home before all my medical problems are known or treated and that I may be given instructions to follow at home. I understand that it is my responsibility to arrange follow-up care and to follow through on any instructions provided.

Document acknowledgement: I certify that I have read and understand the foregoing Treatment Consent and all subsections, and that I am competent and authorized to execute it. I understand that I am not entitled to make any changes or alterations to this legal non-negotiable document. If I refuse to sign the document, service may be denied.

Patient signature (person authorized to consent for patient) and Date & Time	(Relationship to patient)	Printed name
Witness Signature	Date/Time	Printed name

See page 3 for Telephone Consent documentation

Patient Name:	MRN:	DOB:	Sex:

Telephone consent ***(or verbal consent to include those physically unable to sign)***

Today's date (month/day/year) _____ Time _____ Telephone _____

Name of person authorizing _____ Relationship _____

Reason for telephone consent _____

❑ Person authorized treatment/procedure ❑ Person **DID NOT** authorize treatment/procedure

_____ _____

Witness signature and date & time PRINT witness name

_____ _____

Second witness signature and date & time PRINT witness name

