ENGLEWOOD HOSPITAL
AND MEDICAL CENTER

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

Patient Label

1. **CONSENT FOR TREATMENT**
The undersigned consents to any x-rays, laboratory, or other medical procedures or examinations rendered to me under the general and specific instructions of my physician(s). I acknowledge that no guarantees have been made to me as to the result of treatment/examination in the Medical Center. I understand that any evaluation done in the Preadmission Testing Center should not be considered replacement of preventive health screening (i.e. routine annual physical). I do hereby agree and give my consent for admission to Englewood Hospital and Medical Center if appropriate. I also consent to the testing of my blood for Human Immunodeficiency Viruses (HIV) and/or other blood borne pathogens, in the event that any individual at Englewood Hospital and Medical Center is accidentally exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such testing will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.

2. **PATIENT VALUABLES**
The Medical Center requests that patients do not bring medication or other valuables to the Medical Center. Unless deposits for service are necessary, please do not bring large amounts of money with you. If valuables are not deposited in the Medical Center safe, the Medical Center cannot assume responsibility for their loss.

3. **RELEASE OF INFORMATION**
The Medical Center is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligations resulting from my hospitalization and to use data from my medical record for quality, epidemiology and educational studies to which no identifying information will be made public. I understand that occasionally my care and/or portions of my care may be photographed and/or videotaped for educational purposes within and outside of the Medical Center. At no time during this process will my identity (or any information linked to my identity) be revealed. The actual film or videotape will remain in the physical possession of the Medical Center or the physician at all times and will not be released to any other person, agency, or institution unless I specifically authorize it. I consent to the use of photography/videography. I reserve the right to withdraw permission for filming/video/publication upon proper notification. Upon receipt of withdrawal of permission, no further images will be taken.

4. **ASSIGNMENT OF INSURANCE BENEFITS**
In the event the patient is entitled to hospital and/or physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to the Medical Center and/or physician for application to the patient's bill. In the event the patient's insurer denies medical benefits, coverage, or payment, consent is hereby authorized to allow the Medical Center and/or treating physician to appeal such decisions on the patient's behalf.

5. **MEDICARE BENEFITS (IF APPLICABLE)**
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 assign the benefits payable for services to the Englewood Hospital and Medical Center or the physician furnishing the services and authorize Englewood Hospital and Medical Center or the physician to submit a claim to Medicare for payment.

6. **MEDICAID (IF APPLICABLE)**
I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for hospital services to Englewood Hospital and Medical Center and benefits payable for physician services to the physician furnishing the services. I authorize Englewood Hospital and Medical Center or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

7. **ANESTHESIOLOGY, PATHOLOGY, EMERGENCY ROOM, RADIOLOGY, CARDIOLOGY AND OTHER PROFESSIONAL FEE ASSIGNMENT AND CONDITIONS**
In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, the said benefits are also hereby assigned to the Anesthesiologist, Pathologist, Emergency Room Physician, Radiologist, Cardiologist, and/or other appropriate physician. **I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan.** Participation by Englewood Hospital and Medical Center in any given insurance plan does not indicate participation by the above mentioned physicians. I understand that I am responsible to the above mentioned physicians for any charges not covered by my insurance plan.

8. **FINANCIAL AGREEMENT**
The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Medical Center in accordance with the regular rates and terms of the Medical Center. I understand that I am responsible to the Medical Center for any charges billed to and not covered by any insurance carrier(s), including any charges denied by insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, the undersigned agrees to pay costs of collection, including reasonable attorneys fees. All delinquent accounts bear interest at legal rates.

I have received the **Patient Information Package,** which includes the **New Jersey Hospital Care Assistance** information and other pertinent hospital and financial information.

The undersigned certifies that he/she has read and understands the foregoing, receiving a copy thereof and as the patient or the patient's agent, authorized to execute the above, accepts its terms.

Patient's Signature _____ Date/Time _____ Print Patient's Name _____

Signature of Person Authorized to Sign on Pt's Behalf _____ Date/Time _____ Print Authorized Person's Name _____

Witness _____ Relationship to Patient _____

I acknowledge that I have been provided with a copy of Englewood Hospital and Medical Center's Privacy Notice

Patient Signature _____ Date/Time: _____