



DT7000



Atlantic Health System

CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS INCLUDING ADMISSION AND MEDICAL TREATMENT AUTHORIZATION

This form cannot be modified. Any handwritten changes to this form shall not be legally binding or enforceable.

GENERAL CONSENT, AUTHORIZATION, PATIENT RIGHTS AND RESPONSIBILITIES

I authorize Atlantic Health System (referred to as "the Hospital"), Atlantic Medical Group ("AMG"), Hospital staff, AMG staff and the physician(s) participating in my care to render hospital and medical care for my condition, which may include routine diagnostic procedures and such other medical treatment as may be deemed advisable by the physician(s) participating in my care.

I hereby acknowledge receipt of a Statement of Patient Rights and Responsibilities. I understand that professional personnel are available to explain the Statement. Not applicable to Emergency Department Treatment Authorization.

FINANCIAL ARRANGEMENTS

I understand the Hospital charges do not include the fees of my treating physician or the fees for services provided by other Voluntary Medical Staff who may treat me. I understand that I am financially responsible for the payment of my physician fees and these fees may not be covered by my insurance plan.

I authorize the Hospital and all clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

PROTECTED HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI").

AUTHORIZATION TO DRAW BLOOD

In the event that any individual participating in my care is accidentally exposed to my blood or bodily fluids, I authorize the Hospital to draw my blood and test it for the presence of blood borne pathogens such as the Human Immunodeficiency Virus ("HIV").

By initialing here I decline to be tested for HIV and I refuse the disclosure of my blood test results.

VALUABLES

I understand that the Hospital recommends all personal belongings and valuables be sent home with a family member or friend. I assume all risk for loss or damage to any personal belongings retained by me.

OUTPATIENT SERVICES IN HOSPITAL SETTING

I understand that I am having care, testing, procedure(s) or treatment that is considered an outpatient procedure in a hospital setting. As such, there may be different requirements for deductibles and/or copays than for a doctor office visit.

(Initial) I understand that there will be two components to my bill: the professional services provided by my physician and the tests and/or procedures conducted by the Hospital.

SIGNATURE OF PATIENT Date Time (am) (pm) I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility which I would not otherwise have for the services rendered

SIGNATURE OF PERSON SIGNING ON BEHALF OF PATIENT Date Time (am) (pm)

PRINTED NAME OF PERSON SIGNING ON BEHALF OF PATIENT Relationship

PATIENT UNABLE TO SIGN BECAUSE: