TREATMENT/FINANCE CONSENT

CLI.1066 (Rev. 02/19)

ADENA Regional Medical Center

MAIN HOSPITAL NUMBER
(740) 779-7500

BUSINESS OFFICE
(740) 779-4200
800-975-7541

Consent to Medical Care and Treatment: I* acknowledge hereby authorize my provider to perform all tests or procedures relative to my illness, injury or examination necessary for my care and treatment. (* Throughout this document the use of the term "I" will refer to "I and/or my parents or guardians." The use of the term "me" "myself" or "my" shall refer to the patient. The use of "Adena" will refer to Adena Health System, its attending doctors, other doctors, or agents of Adena.) I acknowledge that this authorization enables the provider to obtain preadmission or continued length of stay certifications. I authorize Adena to take photos, video, or audio recording of me for diagnostic, teaching, identification, care conferencing, and quality improvement purposes. I acknowledge that no guarantee has been made about the outcome of the care rendered. I recognize that providers furnishing services to me may be independent contractors.

Release of Information: I authorize Adena to share, release, or exchange all medical information to:

- my providers, including referring providers;
- agencies needed to facilitate continuity of care;
- my insurance company, or its authorized representative, or medical assistance agency;
- any collection agency Adena uses to collect payment for the services rendered; and
- any government authority when required to do so by law.

This authorization includes any information concerning diagnosis of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or testing for Human Immunodeficiency Virus (HIV). In the event of a work-related illness/injury, I hereby authorize the release of all pertinent medical information to the Adena Occupational Health Center and any other party with an interest in the claims defined by Ohio law.
Assignment Insurance Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. If applicable, I authorize any holder of medical or other information about me to release this information to CMS and its agents. I request that payment of authorized benefits be made directly to Adena, on my behalf. I authorize Adena to bill Medicare Lifetime Reserve Days, as necessary. I assign the benefits payable for provider services to the provider or organization furnishing services. If assignment is accepted, I authorize the provider or organization furnishing the services to submit a claim to Medicare and/or commercial insurance carriers for payment. I also assign the benefits payable for private and attending provider services to my private/attending provider or his/her private practice organization; provided, however, that should my provider not accept this assignment for his or her services, this assignment for private and attending provider services shall be null and void.

Financial Agreement: I (or my guarantor, if applicable) understand that I am financially responsible for all services provided, including charges not covered by insurance.

Consent to Contact: I grant permission and consent to Adena and its agents and assignees (1) to contact me by phone at any number associated with me; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text messages or emails using any email addresses I provide; and (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an auto dialer) in connection with any communications made to me or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services from Adena.

Disclosure of Charges: I acknowledge that I am entitled, upon request, to a list of the charges for common medical and surgical procedures.

Notices: I have been advised Adena participates in a Health Information Exchange (HIE). My healthcare provider can use this electronic network to securely provide access to my health records for a better picture of my health needs. Unless I have previously opted out by executing a separate opt-out form, I acknowledge that Adena will allow access to certain health information through the HIE for treatment, payment, or other health care operations. I have been advised I may opt out of such exchange or opt back in at any time by contacting our Health Information Management Services/Medical Records Department. I have been informed that Adena is not responsible for loss or damage to my valuables and personal items. I have been informed that all Adena properties are tobacco free and that tobacco cessation information is available upon request. I have been informed that interpretive services, if needed, are available and will be provided at no cost to me. I acknowledge that Adena's Notice of Privacy Practices and Patient Rights has been made available to me at this or another AHS location. If not, a copy is available upon my request.

Signature: By signing my name below, I certify that I have read and agree to all terms explained in this registration consent form. My questions, if any, have been answered to my satisfaction.

☐ By checking this box, I have indicated that I do not wish to be included in the facility directory.

SIGNATURE:
By signing my name below, I certify that I have read and agree to all terms explained in this registration consent form.

_____ / _____ / _____

PATIENT (GUARANTOR, IF PATIENT IS A MINOR) **DATE/TIME** **WITNESS**

PATIENT IS UNABLE TO CONSENT BECAUSE _____

I, THEREFORE, CONSENT FOR THE PATIENT _____

_____ / _____ / _____

RELATIONSHIP **DATE/TIME** **WITNESS**