Jupiter Medical Center
Jupiter, Florida 33458

CONSENT FOR TREATMENT - GENERAL

CONSENT TO TREATMENT: The undersigned, as the patient, or as the guardian or representative of the patient, consents to such laboratory, diagnostic and treatment procedures/examinations, including a pelvic or rectal exam, considered reasonably necessary for the care and treatment of my condition during my admission for outpatient or inpatient care as rendered to the patient under the instructions of a licensed physician or other health care practitioner.

AGREEMENT TO PAY CHARGES: I hereby assign to the health care entity my right to payment for healthcare services and supplies I receive from the health care entity. I direct anyone paying or receiving money for services or supplies I receive, to pay the money to Jupiter Medical Center or their affiliates. I understand that the health care services I receive may not be covered or paid for, or may only be partially covered or paid for, by my healthcare insurance company or any other third party payer. In the event that the billed charges for the healthcare services I receive are not covered or paid for on my behalf, or are only partially covered or paid, I understand and agree that I am responsible for the payment of the billed charges, or the remaining balance of billed charges for an such service or, if the health care entity has a contractual payment arrangement with my insurance company or third party payer, I will be responsible for the payment of any co-payments, deductibles, and co-insurance for covered services and billed charges for any non-covered services. Any phone number I have provided may be used for the purpose of collecting payments in connection with any services provided by any Jupiter Medical Center provider or affiliate.

PATIENT INFORMATION DISCLOSURE FOR TREATMENT, OPERATIONS AND PAYMENT: The undersigned, as the patient or as the guardian or authorized representative of the patient, authorizes JMC to release any and all information regarding the hospital services and supplies, for the purpose of treatment, operations or payment to any payer or other entity or person deemed necessary by JMC. This includes authorization to release information pertaining to psychiatric and/or psychological care (but not psychotherapy notes), alcohol and/or substance abuse and serologic test results including HIV. JMC may also obtain prescription history from the patient's insurance company and healthcare providers for the purpose of treatment.

MEDICARE AND MEDICAID BENEFITS: I certify that the information given by me in applying for payment under Medicare is correct (including the answers given by me in response to the questions of the Medicare Secondary Payer (MSP) questionnaire), I request payment of authorized Medical benefits on my behalf for services furnished to me by or in Jupiter Medical Center, including physician services, I authorize any holder of medical and other information about me to release to Medicare and its agents my information needed to determine these benefits or benefits for related services.

RELEASE OF LIABILITY AND RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I am responsible for all articles and personal property (money, documents, radios, jewelry, dentures, eyeglasses, hearing aids, etc.) and/or clothing which I retain in my possession (on my person or in my room) and for any other articles and/or clothing which may be brought to me while I am a patient in JMC. I hereby release JMC, physician(s) and team members from any claim for loss, damage to or complete destruction of such property, which is not deposited with the hospital for safekeeping in the hospital safe.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that a copy of the " Notice of Privacy Practices" has been made available to me.

INDEPENDENT CONTRACTORS: I acknowledge that some physicians and other providers operating and practicing in this hospital are not agents or employees of the hospital. These include but are not limited to the following groups: Emergency Physicians, Anesthesiologists, Pathologists, Radiologists, Staff and/or Contract Providers. Physicians and other providers bill separately for their services and may or may not accept my insurance.

STUDENT HEALTH CARE PROVIDERS: I understand healthcare may be provided to me in the form of services rendered by a student health care provider such as a student nurse, respiratory therapist, and pharmacy intern or radiology technology student participating in my care. I understand that by signing this form I am consenting to the supervised care rendered by such health care providers.

DIAGNOSTIC PHOTOGRAPHY AUTHORIZATION: I authorize radiographic films, x-rays, mammograms and other diagnostic films including still, movie or television photography to be taken of me during my hospital stay and consent to the use of such films for medical, scientific or educational purposes.

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WORKERS COMPENSATION: According to Florida Statute section 440.105(7): "Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in **s.817,234."**

TOBACCO FREE ENVIRONMENT: I understand that Jupiter Medical Center is a tobacco-free environment and that I may not use tobacco products including cigarettes, cigars, pipes, herbal tobacco products, and chewing tobacco on the hospital campus or at any facility owned, leased or operated by Jupiter Medical Center. I understand the use of electronic cigarettes or vapor is not recognized by Jupiter Medical Center as a nicotine replacement therapy and their use is also prohibited.

ADVANCE DIRECTIVE QUESTIONS:

1. Do you have an Advance Directive? ☐ yes ☐ no ☐ Unable to respond
2. If yes, is it on file? ☐ yes ☐ no. If no, copy requested? ☐ yes ☐ no
3. If no Advance Directive, copy given? ☐ yes ☐ declined

ACKNOWLEDGEMENT
The undersigned certifies that he/she has read and understood the foregoing and agrees to its terms:

Signature of Patient or Legally Authorized Representative	Date/Time	Printed Name of Patient
Relationship to Patient if signing on Patient's Behalf	Date/Time	Reason Patient Unable to Sign
Witness	Date/Time	

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WELLNESS (OUTPATIENT REHABILITATION SERVICES) PATIENT HISTORY FORM

Date: _____

Name: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Chief complaint/problem: _____

What do you hope to achieve through Therapy? _____

Any prior therapy related to this condition? _____

Medical History (Check all that apply):

- ☐ Pacemaker
- ☐ High/ low blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Congestive Heart Failure
- ☐ Heart murmur
- ☐ Blood clot
- ☐ Stroke
- ☐ Paralysis
- ☐ Blood disease
- ☐ Anemia
- ☐ Bleed easily
- ☐ Memory loss
- ☐ Fainting/ dizzy spells
- ☐ Numbness/ tingling
- ☐ Headaches
- ☐ Night sweats or fever
- ☐ Recent weight loss/ gain
- ☐ Changes in bowel/ bladder
- ☐ Shortness of breath
- ☐ COPD
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Tuberculosis
- ☐ Any lung problems
- ☐ Smoker/ Ex-smoker
- ☐ Kidney problems
- ☐ Bladder/ reproductive infections
- ☐ Incontinence
- ☐ Increased urinary urgency
- ☐ Increased urinary frequency
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Cancer
  Type: _____
- ☐ Liver disease
- ☐ Stress/anxiety
- ☐ Depression
- ☐ Currently pregnant
- ☐ Nausea/ vomiting (other than flu)
- ☐ Seizures/ Epilepsy
- ☐ Hernia
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Neck/ Back injury
- ☐ Arthritis/ Joint pain
- ☐ Broken bones/ Fractures
- ☐ Any metal implants
- ☐ Any allergies:

List:

Other medical history/major hospitalizations/surgeries not listed above:

Have you had any recent tests performed? (Check all that apply)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Blood Tests ☐ Myelogram ☐ Bone Scan

☐ Other: _____

Because of my condition, I have problems: (Check all that apply)

- ☐ Walking
- ☐ Standing
- ☐ Getting in/out of bed
- ☐ Going up/down curbs
- ☐ Kneeling/squatting
- ☐ Pushing/pulling
- ☐ Changing positions in bed
- ☐ Lifting
- ☐ Performing housework
- ☐ Dressing
- ☐ Driving
- ☐ Bathing/showering
- ☐ Picking up objects from ground
- ☐ Carrying
- ☐ Reaching in cupboards
- ☐ Lying down
- ☐ Reading
- ☐ Concentrating
- ☐ Sitting
- ☐ Working at my job
- ☐ Sleeping
- ☐ Doing recreational activities
- ☐ Swallowing
- ☐ Communicating
- ☐ Other:

Are you experiencing any pain? ☐ YES ☐ NO

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MEDICATION RECONCILIATION REPORT
OB & OUTPATIENT AREAS

Patient Name: _____ Date: _____ Source of Information:

DOB: _____ [ ] Patient
Medication Allergies: [ ] Family member

_____ [ ] Other

_____

_____

[ ] NOT TAKING ANY MEDICATIONS [ ] PREGNANT [ ] BREASTFEEDING

Are you on any antibiotics in preparation for this procedure? [ ] No [ ] Yes, if so include on list below

LIST ALL MEDICATIONS YOU ARE TAKING,
INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS

MEDICATION	*DOSE*	*ROUTE*	*FREQUENCY*	*COMMENTS*	*CONTINUE*	*DISCONTINUE*
NEW MEDICATION/CHANGES TO MEDICATIONS FOLLOWING THIS VISIT:						

_____ _____ _____

Admission RN Signature Date Time

_____ _____ _____

Discharge RN Signature Date Time

NURAS47