

Jupiter Medical Center 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 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.



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

Printed Name of Patient

Relationship to Patient if signing on Patient's Behalf

Reason Patient Unable to Sign

Witness

_____ am/pm
Date and Time