Lackey Memorial Hospital

Conditions of Treatment and Admission

Patient Name:	Attending Physician:
Patient Number:	Admission Date:

Consent to Medical Services and Treatment – I am presenting myself for medical treatment to the clinic, and I voluntarily consent to care. Care includes diagnostic tests, medical treatment, and any other treatment option deemed necessary or beneficial to my well-being.

Consent for Virtual Communication Treatment – I consent to treatment by my healthcare provider in a virtual setting that includes: phone conversations, text messaging, patient portal, video streaming, or photography. I consent to being billed for these services when applicable.

Consent to Release Information – I hereby authorize the clinic to disclose to insurance companies, including workers compensation carriers or other parties that may be liable for all or part of the clinic charges, all or part of my clinic records as may be necessary, including any treatment for alcohol or drug abuse or dependence, to determine benefits entitlement and process payment claims for healthcare services provided. The information released may indicate the presence of a communicable or venereal disease which may include but is not limited to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The facility is authorized to disclose all or parts of the patient's medical record as set forth in its Notice of Privacy Practice unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Consent for Testing – I consent to the testing of the patient's blood for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and/or Hepatitis if determined necessary by the Healthcare Provider. Necessary reasons include: diagnostic medicine, treatment of the patient, and protection of staff that have been exposed to bodily fluids in a manner that could transmit such diseases. The undersigned has been informed about the nature of the blood test, expected benefits, and has been given the opportunity to ask questions about the blood test.

Medicare and Medicaid Certification Release – I certify that the information given by me in applying for payment under the *Title XVIII and Title XIX* of the Social Security Act is correct. I authorize medical or other information about me to be released to the Social Security Administration, its intermediaries, or carriers any information needed for this or related Medicare claims. I request that payment authorized benefits be made on my behalf to the clinic or Healthcare Provider who accepts assignment.

Insurance Assignment – I hereby assign to and authorize the clinic and Healthcare Provider involved in my care, to take all steps necessary, without limitations, to ensure that any insurance benefits are awarded. Necessary steps include but are not limited to: billing insurance, filing petitions, filing suit in my name on behalf of the clinic or provider, filing proof of claim, filing probable claims, filing grievances and other similar procedures as may be awarded from time to time with the State Department of Insurance. I also agree to provide and sign any other documents that may be reasonably necessary to accomplish any of these purposes.

Consent for Medication History – I give permission to access my pharmacy benefits data electronically. This will enable access to pharmacy benefits, drug copays, patient's health plan, medication coverage, display therapeutic alternatives, mail order availability, and to download a historic list of medications prescribed for the patient by any provider for review.

Statement for Financial Responsibility – I understand that I am financially and legally responsible for charges not covered in full by a third part payer. I agree that if I should not pay the balance within thirty (30) days after the date of discharge, my account will be

considered delinquent and subject to being turned over to a collection company. I agree to pay costs associated with collections including attorney's fees, collection agency fees, and interest which shall accrue at the maximum rate allowed by law.

About Your Bill – I understand that I will receive a bill for medical services associated with my visit. Services include but are not limited to: procedures, supplies, testing, professional fees, lab test, and office visits. (Examples: pathologist, specialist, radiologist, etc.)

Personal Effects and Valuables – I understand that the clinic shall not be liable for loss or damage of any personal effects or valuables. (Money, jewelry, glasses, dentures, documents, clothing, etc.)

False Claims Act – Any person who knowingly and with intent to insure, defraud, or device any insurance company or files a statement claim containing false, incomplete or missing information, may be subject to prosecution under applicable federal and state laws.

Patient Self-Determination Act – If I am to be admitted to the hospital, I have been offered written materials about my right to accept or refuse medical treatment. I have been informed of my rights to formulate advance directives, I understand that I am not required to have an advanced directive in order to receive medical treatment at this hospital. I understand that the hospital and caregivers will follow the terms of any advanced directive that I have executed to the extent permitted by law.

Acknowledgement of Notice of Privacy Practice – A description of how your medical information will be used and disclosed is summarized on the Notice of Privacy Practice. A complete copy of the Notice of Privacy Practices is posted in the facility and a copy will be proved to you. By signing below, you acknowledge that you have received a copy of the facility's Notice of Privacy Practice.

Smoking Cessation – I understand that Lackey Memorial Hospital and clinics are smoke free facilities and I have received information on Smoking Cessation that I may use or give to someone else I know who smokes.

I certify by signing below that I have read, understand, and agree with the conditions as stated in this form. This Conditions of Treatment and Admissions form shall remain in effect until I prove the clinic or my Healthcare Provider with a written revocation. I may revoke part or all of this form at any time.

Patient Signature/Legal Guardian Signature:_____

Email Address:_____

Date:_____