Lackey Memorial Hospital
Where Community Healthcare is Soaring To New Heights.

CONDITIONS OF TREATMENT AND ADMISSIONS

Patient Name	***Attending Physician***
Patient Date of Birth	***Clinic***
Patient Number	***Date***

Consent to Hospital Care and Treatment: *I am presenting myself for emergency services, outpatient services, or admission to the hospital, and I voluntarily consent to the renders of such care, including diagnostic tests, psychological and medical treatment by authorized agents and employees of the hospital and its medical staff or their designees, as may be deemed necessary or beneficial to my well-being.*

I acknowledge and understand that many of the physicians on staff of this hospital, including the attending physician(s) named above, radiologists, anesthesiologists, pathologists, and emergency physicians, may not be employees of this hospital, but rather are independent contractors who have been granted the privilege of using the hospital facilities for the care and treatment of their patients. I agree to accept their care even though they are not employed by the hospital. I understand that the examination and treatment that I receive on an emergency basis is not intended as a substitute replacement for complete medical care.

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

Special Consent for HIV Testing: *The undersigned specifically consents to the testing of the patient's blood or Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary (1) for determining the appropriate and/or treatment procedures for the patient or (2) for the protection of the attending physician and/or any employee of the facility exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, Its expected benefit, and has been given the opportunity to ask questions about the blood test.*

Consent to Wireless Telephone Calls: *I understand that I authorize the Hospital and all clinical providers who have provided care or interpreted my tests, along with any billing services and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded message, artificial voice messages, automatic dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.*

Consent to Use of Live Video (Telehealth): *I understand that my healthcare provider may share my medical information for the purpose of improving patient care using standard video apps/conferencing technology. I understand that, due to the nature of electronic communications, there is a risk that data could be intercepted, accessed, or compromised by unauthorized third parties.*

Consent for Destruction of Records: *I authorize Lackey Memorial Hospital to destroy my medical records/information in accordance with applicable federal and state privacy and security laws (including HIPAA) after the mandatory retention period has expired.*

Consent for Medical Photography: *I understand that I authorize the hospital and all clinical providers the use of medical photography in connection with medical service received for medical treatment.*

Consent for use of Artificial Intelligence (AI): *To provide you with the best care, we may use AI-assisted documentation tools. An AI scribe may be used to record and transcribe conversations to assist in creating your medical records. The provider reviews all AI-generated notes for accuracy before finalizing them. Your data remains secure and confidential. Participation is voluntary, and you may request to stop the use of this technology at any time without any impact on the quality of your care*

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Personal Effects and Valuables: *I understand that the hospital shall not be liable for the loss or damage of any personal effects or valuables (money, jewelry, glasses, dentures, personal electronic devices such as cell phones/tablets, documents, clothing, etc.).*

Fraud Claims Act: *Any person who knowingly and with intent to insure, defraud, or deceive any insurance company or files a statement claim containing false, incomplete, or misleading information, may be subject to prosecution under the 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 advance directive in order to receive medical treatment at this hospital. I understand that the hospital and caregivers will follow the terms of any advance directive that I have executed to the extent permitted by law.*

Medicare Certification Release: *I certify that the information given by me in applying for payment under the Title XVIII and/or Title XIX of the Social Service Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to the hospital or to the physician who accepts assignment.*

Insurance Assignment: *I hereby assign to and authorize the hospital and physicians involved in care during this period of illness or treatment (herein after-physicians), to take all necessary steps, without limitations, to ensure that any insurance benefits otherwise payable to me or my estate are paid directly to the hospital or physicians. This assignment or insurance benefits includes, but not limited to, billing insurance, filing petitions, filing suit in my name, on behalf of the hospital or physicians, filing proof of claim, filing probate claims and filing grievances and all 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 the other purposes.*

Statement of Financial Responsibility: *I understand that I am financially and legally responsible for charges not covered in full by any third party. I further agree that if I should not pay the balance with thirty (30) days after the date of discharge, my account will be considered delinquent. I agree to pay the cost of collection, including reasonable attorney's fees and costs, collection agency fees and cost, and interest which shall accrue at the maximum rate allowed by law.*

About Your Bill: *I understand that I will receive a bill from the hospital for provision of the hospital services, including staff and equipment, and for any supplies or medicines utilized. I will also receive a bill from any physician who provides professional care to me. For example, I may receive a separate bill from one or more of the following types of physicians who render services to me: my attending or personal physician, emergency room physician, radiologist, anesthesiologist, pathologist or any other specialist.*

Initial Here _____

Authorization to Act as Patient's Representative for Insurance Matters

I hereby authorize Lackey Memorial Hospital and its designated representatives to act on my behalf as my authorized representative with my health insurance plans, including Mississippi Medicaid and MississippiCAN Managed Care Organizations.

This authorization includes, but is not limited to, the authority to:

- *Request, submit, and discuss prior authorizations;*
- *Receive information related to benefit determinations;*
- *File, pursue, and receive determinations on appeals, grievances, and reconsiderations of denied claims or prior authorizations;*
- *Communicate with state agencies, Managed Care Organizations, utilization management entities, and any associated contractors regarding my care and coverage.*

I understand that this authorization applies whether services are approved or denied and remains effective for the duration of the services rendered for this episode of care, unless revoked by me in writing.

I acknowledge that I am not assigning financial responsibility beyond what is otherwise outlined in this agreement, and that this authorization does not waive any of my rights as a Medicaid beneficiary.

Patient Initials: _____

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

PLEASE CHECK ONE----------I DO NOT AGREE_____ I AGREE_____

Patient Advance Directive	**Initial The line below that applies**
I have executed an Advance Directive and will provide a copy for my medical records	_____
I have not executed an Advance Directive and do not wish to do so at this time	_____
I wish to complete an Advance Directive during this hospital stay	_____

I certify that I have read, understand and agree with the conditions as stated in this form

*Patient Signature*_____*Date*_____*Time*_____

Legal Guardian: _____*Date*_____*Time*_____

*Relationship to the Patient*_____

*Patient is a minor child of _____years of age, or is unable to consent because:*_____

Witness: _____*Date*_____*Time*_____