

Memorial Hospital Experience Matters	DATE	
CONSENT FOR MEDICAL TREATMENT - A		

CONSENT FOR MEDICAL TREATMENT: I hereby authorize the personnel of this hospital and members of its medical staff to render to the patient whose name appears on this form care as they deem necessary and appropriate.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this hospital to release my final diagnosis and other medical information to the third parties identified to determine benefits payable.

PHYSICIAN CHARGES: I understand that in addition to any bills I may receive pertaining to facility (hospital) charges, I may also receive bills on behalf of the physicians who participate in my care. These physician charges are not included in the bill from the hospital. (Note: when verifying your insurance coverage for your hospital stay, please verify your coverage for the physician groups that may contribute to your care.)

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of this hospital of any insurance, personal injury or other benefits otherwise payable to me or the patient. The undersigned acknowledges the responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party source.

GUARANTEE OF PAYMENT: I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay the hospital's charges in full when rendered. I also acknowledge that interest may be charged to unpaid balances over thirty days from the date payment is due. In the event that the account is referred to collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (applies to Medicare Patient Only) I hereby certify that the information given by me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payors 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 related Medicare claim. I hereby authorize this hospital to use my sixty (60) Lifetime reserve days Medicare coverage. I have received *An Important Message From Medicare* (inpatients only).

PERSONAL VALUABLES: Patients are encouraged to leave all money and valuables at home. The hospital shall not be responsible for the loss of or damage to any personal property the patient has brought into the hospital inclusive of dentures and glasses.

PATIENT RIGHTS AND RESPONSIBILITIES: I have received information about Patient Rights and Responsibilities.

NOTICE OF PRIVACY PRACTICES: My initials acknowledge that I am in receipt of the MedStar Privacy Practices Brochure: _____ Initials

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO THE MARYLAND INSURANCE ADMINISTRATION. Under Maryland law, I have the right to contest a decision by an HMO or insurer that a proposed or delivered health care service was not medically necessary. The law allows the Health Advocacy Unit of the Attorney General to assist me in filing an internal grievance with the HMO or insurer and allows me to externally appeal the final decision to the Maryland Insurance Administration. A health care provider may also file an internal grievance or external appeal on my behalf. I authorize a health care provider to file such a grievance or appeal. Maryland law permits the Insurance Administration to receive advice from medical experts or Independent Review Organizations while determining whether to uphold or overturn the HMO or insurer's decision that a health care service was not medically necessary. Throughout the grievance or appeal process, the confidentiality of my medical records will be maintained in accordance with Maryland and Federal law. I understand that if I have questions about the contents of my medical records to be released, I should contact my health care provider. In the event I, or a provider on my behalf, files a grievance or an appeal, I authorize the release of medical records to the Health Advocacy Unit of the Attorney General and the Maryland Insurance Administration as follows: (1) I authorize the Attorney General and the Insurance Administration to obtain medical records and insurance information related to my complaint or appeal, (2) I also release any medical records obtained on my behalf to the Attorney General, (3) I further authorize the Maryland Insurance Administration to release my medical records to medical experts who may assist the Maryland Insurance Administration with my appeal. I understand that my records may be used to develop general statistical information on my complaints and appeals filed, and any statistical reports will not identify me or contain any identifying information. I am not authorizing the release of any information that would identify me to anyone not mentioned above. This authorization is valid for a period not to exceed twelve (12) months from the date of my signature below.

I CERTIFY THAT 1) I UNDERSTAND THE CONTENTS OF THIS FORM AND 2) ALL INFORMATION GIVEN THE HOSPITAL, INCLUSIVE OF INSURANCE INFORMATION IS ACCURATE AND CORRECT. A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

Signature (Seal)

Date

Patient Name (Please Print)

Witness

Authorized Person's Signature

Relationship to Patient

Reason patient unable to sign (check one): Minor Condition

