

# **CONSENT & ACKNOWLEDGMENT**

# **GENERAL CONSENT TO CARE**

I am presenting myself as a patient of Grace Cottage Family Health & Hospital. I voluntarily consent to such health care as may be validly ordered or recommended by any authorized physician or other medical professional. This care may include laboratory tests, x-rays and other diagnostic procedures and medical treatment. I acknowledge that GCFH&H cannot guarantee the effect of such examination or treatment.

## **RELEASE OF INFORMATION**

I consent to the release from my medical records by my insurance carrier or medical professional responsible for my care of such information as may be necessary. This may include electronic access to my medication history information which may include insurance benefits, eligibility and formulary information, prescribing provider and pharmacy, medication history, as well as prescription refill and renewal information. I also consent to GCFH&H's use and disclosure of such information necessary to carry out treatment, receive payment, or carry out health care operations as described in the GCFH&H Joint Notice of Health Information Practices. I acknowledge I was offered the Joint Notice of Health Information Practices.

## **AVAILABILITY OF PHYSICIANS OF MEDICINE OR OSTEOPATHY**

GCFH&H may not have a physician of medicine or osteopathy in the facility at all times. There is always a physician on-call 24/7, but not on premises at all times. At certain times there may be an advanced practice professional, such as a physician assistant or nurse practitioner, in the facility to render medical care. Advanced practice professionals who provide hospital care always have access to an on-call physician. A physician is always available to come into the hospital if needed to render care.

# **TELEMEDICINE HEALTH SERVICE** (*if applicable*)

Telemedicine is the use of live interactive audio and video to enable a healthcare provider at a different location from you to provide healthcare services to you, such as diagnosis, treatment, and/or consultation services. As this type of visit with a provider may be different than healthcare services you are familiar with, it is important that you understand the following:

- 1. The Dartmouth-Hitchcock telemedicine provider will be at a different location from you. A physician, nurse, or other trained individual may be present in the room with you to assist in or observe the telemedicine service.
- 2. Non-medical technical personnel may be present in the area where telemedicine is being performed.
- 3. The Dartmouth-Hitchcock telemedicine provider will need access to all relevant health care information available to inform your care and treatment. Your health information, including details of your medical history, examinations, x-rays and tests, may be shared with the Dartmouth-Hitchcock telemedicine provider orally or electronically by your other healthcare providers.
- 4. There are benefits and opportunities associated with telemedicine, including but not limited to, having access to healthcare and to medical specialists without having to travel outside of your local community. There are also limitations to delivering healthcare services through telemedicine. For example, the use of interactive video technology may be insufficient to allow for treatment, diagnosis or general medical care decisions to be made. In addition, delays in medical evaluation and treatment may occur due to failures of the electronic equipment or failure or interruption of the internet connection.
- 5. All services provided to you through telemedicine will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (to the extent required by law; in certain circumstances, this requirement may not apply). State and federal laws regarding confidentiality of your medical information apply to information created and disclosed during the telemedicine service.
- 6. There will be no videotaping or recording of your telemedicine care without your consent.
- 7. The medical records of your telemedicine health services provided by Dartmouth-Hitchcock providers will be maintained by GCFH&H but may also be stored in the Dartmouth-Hitchcock electronic medical record. If you need copies of these records, please follow GCFH&H's 'Notice of Privacy Practices'.
- 8. Your participation in a telemedicine service is voluntary. You may withhold or withdraw consent to the telemedicine at any time without affecting your ability to receive future care or treatment. A copy of this consent will be maintained in your medical record.

#### PATIENT RIGHTS

I understand that GCFH&H's Notice of Privacy Practices provides information about how they may use and disclose my protected health information. I understand that in addition to the copy GCFH&H will provide me, copies of the current notice are available by accessing their website at <u>www.gracecottage.org</u>.

#### PERSONAL BELONGINGS

I understand that GCFH&H is not responsible for my personal belongings or valuables. Belongings and/or valuables include, but are not limited to clothing, eyeglasses, eye lens, dentures, jewelry, keys, cell phones, cash, and other similar items.

### FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS & TERMS OF PAYMENT

I hereby agree to direct payment and benefits payable from me to GCFH&H to cover outstanding balances. If I have no insurance or coverage is denied I understand that I am financially responsible to GCFH&H for the payment of my account in full. I understand and agree to the following payment terms:

- All accounts are due when and as billed unless prior payment arrangements are made with the business office.
- Should my account be referred for collection, I shall be liable for all costs of collection, including reasonable attorney's fees and/or collection expenses.

### **AUTHORIZATION FOR THE USE OF PHOTOGRAPHS**

I hereby authorize GCFH&H staff to make and use any images of wounds or other relevant images, to be included in my medical record for treatment and educational purposes. This authorization extends to copies of any said images. I understand that my identity will be protected in the use of these images for purposes other than my medical record.

Recording: I understand that GCFH&H uses surveillance cameras in certain public spaces or common areas in the facility, including but not limited to, hallways in the Emergency Department. I also understand that there are occasions when GCFH&H must provide patient care in such areas. I understand that I provide my consent if I am provided care or treatment in such a space. Images captured by surveillance video are for security purposes only and are only temporarily stored.

### **MEDICARE PATIENTS**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the provider(s) for whom GCFH&H is authorized to bill in connection with its services.

(Authorization must be signed by the patient, or by an authorized person in the case of a minor or when a patient is physically or mentally incompetent.)

You are entitled to a copy of this agreement at any time. Keep it to protect your legal rights. Signature: Patient Patient Printed Name D.O.B Date: If the patient cannot or is unable to sign consent for care, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient must be obtained. □ Patient unable to sign this form due to severity of illness at time of treatment □ No patient/legal representative available to sign at time of treatment □ Verbal consent received and witnessed due to precautions of visiting patient □ Other reason patient did not sign: \_\_\_\_ Signature: \_\_\_\_\_\_ Authorized Person Date: Authorized Person Printed Name This consent is valid for a period of one year from execution unless sooner revoked by patient or authorized patient representative or until treatment is completed. Interpreter/Translator: (To be signed by the interpreter/translator if the patient required such assistance) To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form. Signature of Interpreter/Translator: \_\_\_\_\_ Date: \_\_\_\_