Gwinnett Hospital System

PLACE LABEL HERE

CONDITIONS OF ADMISSION/ CONSENT FOR TREATMENT

(See reverse)

I (We), the undersigned, have read and fully understand the Conditions of Admission and Consent for Treatment on the reverse. My signature acknowledges that I have been given the opportunity to satisfy myself by asking questions about the Conditions of Admission/Consent for Treatment. I voluntarily give my consent to hospital care, and I accept the conditions of hospital care. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.

SIGNED _____ _____

Patient/Patient's Representative — Date

_____ _____ _____

Relationship if Other than Self — Witness — Date

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT: In consideration of the Hospital's advancing credit to me for my hospital care and services, I hereby irrevocably assign and transfer to Gwinnett Hospital System and treating Physicians all benefits and payments now due and payable or to become due and payable to me under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, under any third-party actions against any other person or entity, or under any other benefit plan or program (hereafter referred to as Benefits) for this or any other period of hospitalization and related outpatient care. I understand and acknowledge that this assignment does not relieve me of my financial responsibility for all hospital charges and treating Physician charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to the Hospital and treating Physicians by any Benefit plan or program.

SIGNED _____ _____

Patient/Patient's Representative — Relationship if Other than Self

REQUESTS FOR SPECIAL ASSISTANCE:

Our staff wants to communicate effectively with you or other persons participating in your care or treatment who may be deaf/hearing impaired or have other special needs. Sign language and oral interpreters, TDD's (telecommunications device for the deaf), closed captioning for televisions, volume-control telephones, and other auxiliary aids and services are available free of charge to people who are deaf or hard of hearing. Further, the hospital can provide foreign language interpretation services for those patients who require such assistance. For assistance, please contact any hospital personnel or the Patient Representative Office at 678-312-4399.

_____ (Patient/Patient's Representative Initials)

For Gwinnett Hospital Use Only:
INTERPRETIVE SERVICE USED ON THIS ENCOUNTER

Interpreter used - Name or Number_____

Date/Time_____ Language _____

PLACE LABEL HERE

CONDITIONS OF ADMISSION/ CONSENT FOR TREATMENT

1. **CONSENT FOR TREATMENT:** I hereby apply for and consent to Admission and Treatment by this Hospital and its Medical Staff, and authorize all routine hospital procedures and services and treatments, examinations, and diagnostic procedures, including but not limited to the use of X-rays, laboratory specimens, drugs, anesthesia, and surgical operations or procedures as may be ordered by my treating physician(s). I further consent to the observation and participation of personnel-in-training and students in my care and treatment. I also certify that no guarantee or assurances have been made as to the results that may be obtained. ***I consent to the disposal by hospital authorities of any specimens, tissue or parts that may be removed from my body during my hospitalization. If you have a different request for the handling of any of these specimens, tissues, or parts please speak to your nurse. For disposition of fetal remains use Attachment E of Policy 7009-02 Fetal Death. For all other tissues please use the GHS Request and Authorization Form for release. See Attachment F of Policy 7709-02***

2. **COMPLIANCE WITH HOSPITAL POLICIES AND PROCEDURES:** I agree to comply with all hospital policies and procedures, including the hospital "NO SMOKING" policy.

3. **PERSONAL VALUABLES:** I understand Gwinnett Hospital System provides facilities for the safekeeping of valuables. I hereby release Gwinnett Hospital System from any responsibility due to loss or damage of any valuables or personal belongings that I may keep in my possession, or may be brought to me by other persons.

4. **AUTHORIZATION TO PROCESS CLAIMS & RELEASE OF INFORMATION:** I authorize Gwinnett Hospital System and the independent contractor physicians and/or professional corporations that render services to me to process claims for payment by my insurance carrier on my behalf for covered services provided to me at Gwinnett Hospital System. I authorize the release of necessary information, including medical information, regarding medical services rendered during this admission or any related services or claim, to my insurance carrier(s), including any managed care plan or other payor, past and/or present employer(s), Medicare, Champus, authorized private review entities and/or utilization review entities acting on behalf of such insurance carrier(s), payers, managed care plans and/or employer(s), the billing agents and collection agents or attorneys of Gwinnett Hospital System and/or the independent contractor physicians and/or professional corporations, my employer's Worker's Compensation carrier, and, as applicable, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purposes(s) of satisfying charges billed and/or facilitating utilization review and/or otherwise complying with the obligations of state or federal law. Authorization is hereby granted to release health record data and/or copies to my attending and/or admitting healthcare professional and/or any consulting healthcare professional and/or any healthcare professional I may be referred to for follow-up care. I further authorize Gwinnett Hospital System and any other healthcare provider or professional rendering services to me to obtain from any source medical history, examinations, diagnoses, treatments and other health or insurance authorization information for the purpose(s) of satisfying charges billed and/or facilitating utilization review, providing medical treatment and/or the evaluation of such treatment, and/or otherwise complying with the obligations of state or federal law. A photocopy of this Authorization may be honored.

5. **MEDICARE PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST:** 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 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.

6. **NOTICE:** The physicians, dentists, oral surgeons, podiatrists and psychologists at the Gwinnett Hospital System are independent contractors of the Hospital and are not its employees or agents. As independent contractors, the physicians, dentists, and oral surgeons, podiatrists, and psychologists are responsible for their own actions. I understand that I may receive separate bills for their services. I also understand that such practitioners who render services to me may not be participating members of my managed care health plan. My plan may consider these services as non-covered services. Consequently, I understand that, in the event that my managed care health plan does not reimburse these non-participating physicians in full for services provided to me, my managed care health plan may make me responsible for any balance that it declined to pay for such services.

7. **PATIENT RIGHTS:** This hospital will admit and treat all patients without regard to race, national origin, religious creed, age or sex and the same medical criteria for admission are applied to all. In addition your rights include, but are not limited to, the right to be treated with dignity, to know the identity of your caregiver, to participate in decisions regarding your care and to determine the extent to which family members participate in your care, to have an advance directive, to privacy, security and communication with people outside the hospital, to access pastoral care and advocacy services, to consent to or decline treatment (including research), to be free of restraints or seclusion imposed as a means of coercion, discipline, convenience or retaliation by staff, and you have a right to access an internal grievance process through contact with the Patient Representative, Department of the hospital or to seek external review of your concerns by contacting the Department of Human Resources Office of Regulatory Services at Two Peachtree St., NW, Atlanta, Ga. 30303-3142, or by phone at 404-657-5700.