Thayer County Health Services

120 Park Ave.
Hebron, Nebraska 68370
Hospital: 402-768-6041 Clinic: 402-768-7203

Account Number | **Stay Type** | **MR Number** | **Admission Date**

Patient Name | **Gender** | **DOB** | **Pt Age** | **Rm #**

Patient Address | **City** | **Stat** | **Zip**

Admitting Provider | **Primary Provider**

CONSENT TO HOSPITAL / CLINIC AND MEDICAL TREATMENT

Medical Consent: I hereby acknowledge that I (or, if signing on behalf of the patient, the patient) have a condition requiring hospital/clinic or medical care, do hereby voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by my treating practitioner, his/her assistants, or his/her designees, including hospital/clinic personnel, as is determined necessary in his/her judgment. This consent is designed to cover all procedures in the hospital or clinic which do not require a specific consent form; I understand that I have (or the patient has) the right to refuse treatment and that my signature below is not a consent to any non-routine or non-emergency procedure. The treating practitioner and/or a member of the nursing staff may ask me to sign a form consenting to special medical or surgical procedures. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in Thayer County Health Services Hospital and/or Clinic ("TCHS").TCHS encourages patients to insist on any additional information necessary to make an informed decision to consent to or refuse treatment. I acknowledge that some physicians and certain other practitioners providing services to me are independent contractors, and are not employees or agents, of TCHS.

Continuing Outpatient Care: In some cases, proper treatment of a medical condition requires treatment over the course of repeated outpatient visits. In such cases, the requests, consent, and agreements contained herein are valid and shall apply to all repeat visits and continuing treatment and diagnosis for the same condition, except for the elections related to electronic health information exchange, which will remain valid unless and until I change my designation in the manner described below.

Authorization for Release of Medical Information: I hereby authorize TCHS to furnish to any person or entity which may be responsible for any portion of the charges incurred, including, but not limited to, the insurance carrier(s) or their agents identified on the face sheet attached to this form, such information as it or they might need or request concerning my treatment at TCHS. I agree to the transfer of medical information to the health care provider(s) or facility that will provide continuation of my health care. A photocopy of this authorization shall be considered as valid as the original.

Financial Agreement: I agree to promptly and fully pay all charges for services and supplies provided by TCHS, physicians, and others providing services in accordance with their regular rates and terms. I hereby personally obligate the patient, and also personally obligate myself if signing as the patient, the spouse of the patient, the parent of a minor patient, or the legal guardian of a patient, for payment of all such charges at the regular rates to the extent not covered by insurance, and agree to pay any charges which, for any reason, are not promptly paid by insurance. I authorize TCHS to post payments or move credit balances to any open accounts for myself or my family. I authorize TCHS to obtain one or more credit reports on the patient and/or me. I understand that it is my responsibility to obtain any prior approvals required by an insurer, and to take all other steps to qualify for insurance coverage; I will determine whether my insurer requires pre-certification before I receive services from TCHS. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder.

Assignment Of Insurance Benefits: I certify that the information given by me is correct. I hereby authorize and assign to TCHS, for services provided by TCHS and its employees or others working under contract or arrangement with TCHS, all coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to TCHS. I further assign to and direct payment to all physicians providing services to me at TCHS, and billing separately for their services, all coverage and benefits available for such services. Any credit balance resulting from benefit payment or other sources may be applied to any other account owed by me or the undersigned to TCHS. This assignment specifically includes, but is not limited to, all benefits for all medical and hospitalization insurance; accident insurance; disability or loss-of-time insurance; Medicare, Medicaid, and CHAMPUS; benefits payable by alternative delivery systems such as HMOs and PPOs or arising from worker's compensation or occupation disease claims; and proceeds to which I am, or my estate is, entitled because of any judgment, settlement, or other claim or cause of action for damages if I was or am injured. This assignment may not be revoked as to services provided during this hospitalization or course of diagnosis and treatment. I also understand I am responsible for any amount not covered or paid by my insurance benefits authorized by this assignment.

Acknowledgement of Patient Rights and Responsibilities & Notice of Privacy Practices: I was given the following notices*: (a) information on patient rights and responsibilities; and (b) the TCHS Notice of Privacy Practices:

*_ during this admission / encounter *_ during a previous TCHS encounter

Consent For Telemedicine: I hereby consent to the use of telemedicine services ordered by my attending physician or treating practitioner. I understand that the consulting provider will be at a different location from me. I can decline telemedicine services at any time without affecting my right to future care or treatment and any program benefits to which I would otherwise be entitled cannot be taken away. If I decline the telemedicine service, alternatives will be discussed including but not limited to transfer to another facility. TCHS personnel will use real time video to transmit or share necessary details of my medical history, examinations, x-rays, tests, photographs or other images with the telemedicine provider. Video or audio during the consultation will NOT be recorded. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without my written consent. The same confidentiality protections that apply to my other medical care also apply to the telemedicine service. I have access to all medical information resulting from the telemedicine consultation as provided by law.

Authorization of Communications from TCHS: I consent to be contacted by regular mail, by e-mail, or by telephone (including a cell phone/wireless number) regarding any matter to my account(s), by TCHS or any entity to which TCHS assigns my account(s). This includes contact for the purpose of scheduling, telemarketing, debt collection, or other purposes. I consent for TCHS to use technology, including automated technology such as auto-dialing or pre-recorded messages, to contact me at the address, e-mail address, or telephone number, including any cell phone/wireless number, I have provided, or any updated or additional contact information I provide at a later time. I agree, subject to state or federal law, to pay all costs, reasonable attorney fees, expenses, delinquent charges, and interest in the event TCHS has to take action to collect the same because of my failure to pay in full. This consent applies to all health care providers and agents covered under this agreement. If I discontinue use of any cell phone number provided, I shall promptly notify TCHS and hereby indemnify TCHS and its agents and independent contractors from any expenses or other loss arising from any failure to notify.

Photographic Consent: I hereby consent to the taking and use of pictures, and, where applicable, use of video recording, of my (or, the patient's) surgical condition or treatment, for diagnosis or treatment, identification, or for TCHS operations, including peer review and education or training programs.

Preservation of Tissue: I hereby authorize TCHS to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissue taken from my (or the patient's) body during any hospital/clinic procedure(s).

Notice of Medical Provider On-Site: TCHS does not have a Doctor of Medicine or Doctor of Osteopathy present in the hospital 24 hours per day, 7 days per week. In the event you are admitted as an inpatient, observation patient, or outpatient surgery patient, be advised that TCHS has available on call a Doctor of Medicine or Doctor of Osteopathy, a Physician Assistant or a Nurse Practitioner serving the hospital to meet your medical needs. Although these medical providers are not in-house all of the time, they are readily available to meet your health care needs in accordance with federal regulations.

CyncHealth and CommonWell: TCHS participates in CyncHealth (state-wide) and CommonWell (nationwide), which were developed to share information so that participating health care providers can quickly view your health information when caring for you. TCHS will not share patient information with CyncHealth which is entitled to confidentiality under more stringent federal or state laws, such as alcohol and substance abuse treatment program records protected under 42 CFR Part 2; records related to emergency protective custody proceedings; predictive genetic testing information used for genetic counseling purposes; and HIV testing information. By signing below, I acknowledge that I have received education about CyncHealth and CommonWell, and I understand that patient information will be included in CyncHealth and CommonWell unless I choose to opt out.

Patient Directory: I understand that unless I object, my (or the patient's) name and location within TCHS will be included in the patient directory and this information will be given to those who ask for the patient by name. I understand that if I object to inclusion in the patient directory, family and friends who ask for me (or the patient) by name will be informed there is nobody by that name in the patient directory, and that calls, flowers, and mail will not be delivered to the patient. I understand that I may notify TCHS of my objection to inclusion in the patient directory at any time during this hospital stay.

Personal Valuables: TCHS maintains a safe for the safekeeping of money and valuables; and TCHS shall not be liable for the loss or damage to any personal property unless the same are deposited with TCHS for safekeeping.

Medicare Patients Only - Assignment and Certification: I request payment of authorized Medicare benefits on my behalf for any services furnished to me by or in TCHS. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I certify that the information I have provided to TCHS is true, accurate, and complete.

I [check one] (a) HAVE _____ (b) HAVE NOT ____ been in a hospital or nursing home on a Part A skilled stay within the past 60 days.

If (a) checked, given name of hospital or nursing home:_____ Length of Stay (days) _____

Medigap Patients Only - Assignment of Medigap Benefits: I request that payment of authorized Medigap benefits be made on my behalf to TCHS for any services furnished by it to me. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. Until revoked, this authorization applies to all occasions of service. This assignment is specific to the supplemental insurance information provided during registration (see scanned copy of the insurance card for policy number).

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ OR HAS HAD READ TO HIM/HER THE FOREGOING, RECEIVED A COPY THEREOF, AND IS THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR ONE DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S AGENT TO SIGN AND AGREE TO THIS DOCUMENT. BY SIGNING BELOW, I CERTIFY THAT THIS CONSENT TO HOSPITAL/CLINIC AND MEDICAL TREATMENT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

_____
Name of Patient (Print)

_____ _____
Signature of Patient/Legal Guardian/Authorized Representative Date

_____ _____
Relationship to Patient (if not Patient) Reason Patient Unable to Consent

_____ _____
Signature of Witness Date