

General Consent for Treatment

What is Authorization for Medical Treatment?

Authorization for Medical Treatment is referring to the patient/ patient's guardian allowing our medical team to provide the patient medical treatment.



AUTHORIZATION FOR MEDICAL:

I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of Westchester Medical Center (WMC), to provide medical treatment to me or the above-named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood as well as access to my medication history data. I understand and authorize the administration of pharmaceutical agents and medications by any one of several techniques including peripheral intravenous access (inserted into a vein in an arm or leg) and peripheral insertion of a venous catheter that then enters the central circulation (PICC line). I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at WMC. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information.

What is Release of Medical Information?

Release of Medical Information is referring to the patient/ patient's guardian allowing our medical team to release the patient's medical information to their attending physician, insurance carriers, and/or third-party payors.



RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct WMC and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third-party payors and employers of self-funded plans.

What are Assignment of Benefits, Guarantee of Payment, & the Financial Assistance Program?

The patient authorizes and directs their insurance carrier and/or healthcare plan to make payment of any and all such amounts directly to WMC, rather than to the patient or any other insured. As well as agreeing to make payments on any service that their insurance does not cover. If a patient is not insured, WMC does offer a Financial Assistance Program.



ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND FINANCIAL ASSISTANCE PROGRAM: I hereby assign to WMC any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by WMC, whether such services are considered in-or out-of-network with respect to any third-party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to WMC, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to WMC for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. I understand I will receive a separate bill from my attending physician, emergency department physician, radiologist, anesthesiologist, and other consultants. (However, if treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules.) As part of WMC's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. WMC has a Financial Assistance Program for patients who financially qualify. Please ask for more details.

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What is consent to receive telephone calls, texts and/or emails?

If WMC is unable to speak to a patient face-to face, the patient is giving WMC permission to contact them electronically.



CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND/OR EMAILS: I hereby consent to WMC to contact me by voice call, text message and email at the Account contact telephone number (s) and Email address (es) reflected on my account. I understand that, by giving this consent WMC may contact me about my medical care, or my account, such as appointment, the results of any tests or procedures, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

What is acknowledgement of receipt of important information about paying for your care?

The patient is acknowledging receipt of the important information about paying for their care. This is also accessible via the QR code link to our website.



ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE

By signing below, I acknowledge receipt of the important information about paying for your care.

What is Telepsychiatry?

Telepsychiatry is referring to the use of telecommunications technology to deliver psychiatric care remotely.



TELEPSYCHIATRY: I have been given basic information regarding the use of Telepsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with, and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Telepsychiatry services, in which case evaluations will not be withheld, but will be conducted in-person by appropriate clinicians. I also understand that upon my refusal of such services I will be apprised of the alternatives to Telepsychiatry services, including any delays in service, need to travel, or risks associated with not having the services provided by Telepsychiatry. Furthermore, I am made aware that each Telepsychiatry session shall not be recorded without my consent.

☐ I do not want to participate in Telepsychiatry

Telepsychiatry- Below, you will initial on the blue line, stating that you do not want to participate in telepsychiatry.

General Consent for Treatment

RELEASE OF LIABILITY FOR PERSONAL PROPERTY:

I understand and agree that personal property (i.e. money, jewelry) should not be brought into the hospital and understand and agree that WMC shall not be liable for loss or damage to any personal property. Please initial in the space provided to the left

Release of Liability – Below, you will initial on the blue line indicating that you are aware that the hospital is not responsible for any personal belongings left behind.



What is Medicare Reserve Days?

Medicare Reserve Days are additional days that Medicare will pay for when you're an inpatient in the hospital for **more than** 90 days.

IF ADMITTED AS AN INPATIENT:

I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare" (if a Medicare recipient), information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient) with information about how I can exercise the right explained in these materials. In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days. **I do not authorize WMC to utilize my Lifetime Reserve Medicare days.**

Medicare Reserve Days – Below, you will initial on the blue line indicating you do NOT authorize WMC to utilize your lifetime reserve Medicare days. ***This is only obtained when a Medicare patient is being admitted.**



DESIGNATED CAREGIVER:

I authorize WMC to share my PHI with my designated caregiver(s). Please initial in the space provided to the left.

If you are signing this Consent as the patient's Authorized Representative, put an "X" in the box that shows your legal relationship to the patient:

- | | |
|--|---|
| ☐ pediatric patient's parent, guardian, custodian, or foster parent | ☐ patient's legal guardian |
| ☐ patient's spouse or domestic partner or surrogate | ☐ patient's healthcare proxy |
| ☐ other legal relationship: _____ | |

***A selection should be based on the representative's relationship to the patient.**

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PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____

Patient

Signed: _____

Legal authorized Representative

Witness: _____

Date: _____ Time: _____

TELEPHONE CONSENT IF GRANTED BY (if required)

Signed: _____

Name of legal representative and relationship to patient.

Signature of call

Witness: _____

Date: _____ Time: _____

Signatures – Please sign for General Consent for treatment today.

First signature is required from an adult patient, anyone 18+

Second signature is required from the patient's legal representative (Guardian and/or HCP)

Signature on the right- is required when obtaining Verbal consent.

OFFICE USE ONLY:

- ☐ Patient is unable to provide consent due to condition
- ☐ Patient refused to sign

Hospital Staff Person's Name

Date & Time

Office Use Only – The Registration Representative will select one option when the patient either refuses or is unable to sign due to medical condition. The Registration Representative will sign and indicate date and time of signature.