

iPad eForms

Obtaining Consent on the iPad:

You can select the patient from the list or search the patient using the Name, MRN, or FIN.

12:08 PM Mon Oct 21

Patient eSignature Fermin, Victor

Profiles Search Patient List Refresh

Filter by Patient Name, FIN or MRN

ZZZTEST, MICHAEL 63 years Male DOB: Feb 16, 1961 MRN: 1254588 FIN: 124540948	PreReg MH Main Building MH PreAdmit
ZZZTEST, MICHAEL 48 years Male DOB: Jun 1, 1976 MRN: 2854588 FIN: 124540948	PreReg MH Main Building MH PreAdmit
ZZZTEST, MICHAEL 73 years Male DOB: Nov 3, 1950 MRN: 4874588 FIN: 124214448	PreReg MH Main Building MH PreAdmit

Select Patient by tapping the name.

A list of missing & completed consent forms will appear

3:04 PM Fri Sep 20

Patient eSignature Fermin, Victor

Form Selection + Present to Patient

Forms for Completion
Select a row if you want to mark as complete or postpone a form.

Care Act - MHRH Required	
General Consent for Treatment - MHRH Required	
HIE Consent - MHRH Required	
Important Message From Medicare - MHRH Required	
No Surprise Act Disclosure Form - MHRH Required	
Notice of Privacy Practice - MHRH Required	
NYS External Appeal - MHRH	

Completed Forms

HIE Consent	Mar 30, 2024 06:12
Patient Registration Supplemental Form	Mar 30, 2024 06:12

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Form 1 of 3

WMC Health MidHudson Regional Hospital
Westchester Medical Center Health Network

GENERAL CONSENT FOR TREATMENT

3603 (Rev. 09/23) Page 2 of 2

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:

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", 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. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information. 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.

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: _____

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE **TELEPHONE CONSENT IS GRANTED BY (if required)**
Signed: _____ Signed: _____
Legal authorized Representative Signature of caretaker
Witness: _____ Witness: _____
Date/Time _____ Date/Time _____

OFFICE USE ONLY:
☐ Patient is unable to provide consent due to condition

The locations where a signature is needed will be highlight in blue.

Tap the blue box and have the patient sign in the white box and tap "Done" when finished.

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Signed: _____ Signed: _____
Legal authorized Representative Signature of caretaker
Witness: _____ Witness: _____
Date/Time _____ Date/Time _____

OFFICE USE ONLY:
☐ Patient is unable to provide consent due to condition

Signature

Reset Cancel Done

Please sign below

Decline Clear