



Saint Luke's Health System

Consent and Agreement of Health Care Services

CONSENT FOR TREATMENT

I consent to and authorize Saint Luke's Health System's entities and physicians to provide healthcare services under the general and specific instructions of members of the medical staff. I further consent to any examinations, tests or procedures that may be deemed advisable or necessary in the diagnosis and treatment at the discretion of the professional staff. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I authorize the Entity and my physicians to take photographs or other images of me or parts of my body while under the care of the Entity for use in medical evaluation, education or research. The Entity does not routinely test all patients for hepatitis or for the human immunodeficiency virus (HIV). However, in the event that my physician feels it is necessary or in the event that a health care worker, employee, or volunteer is exposed to my blood or other body fluids, my blood may be tested for hepatitis or HIV infection. If my blood test indicates infection, my physician will be notified.

PROFESSIONAL CARE

The patient is under the professional care of an attending physician who arranges for services for the care and treatment of the patient. I realize that among those who provide patient care at this entity are medical, nursing and other health care personnel in training who may be participating in patient care as part of their education.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of all or any part of the patient's medical and accounting record, including records which may contain information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness or psychiatric treatment, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid or other private or public health or hospital care insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer, which may be needed in order to process any entity or physician claim relating to this hospitalization or outpatient service. I also authorize the Entity to release information needed for billing purposes to physicians or entities that provide services to me related to my admission to the entity. I also authorize the System to review my medical records to gather data for research purposes. I understand that no information that will identify me in any way will be published.

I also consent to the sharing of my health information within the Saint Luke's Health System for the purposes of treatment, payment, and healthcare operations. Information may also be provided to any other physician or healthcare provider that I identify as being involved in my continued treatment.

ASSIGNMENT OF BENEFITS

I hereby assign to Saint Luke's Health System's entities and any or all physicians, all of my interest and right to the insurance benefits otherwise payable to me for this hospitalization or outpatient services arising out of any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of hospital benefits (including major medical) directly to the hospital, which provided care. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim for payment. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering said hospitalization or outpatient service and that the entity is not responsible for precertification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of precertification and/or any charges not covered by this assignment of benefits.

AUTHORIZATION TO FILE AN APPEAL ON PATIENT'S BEHALF

I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and they may deny payment of a portion of my Entity billing. To assist me in resolving this dispute, I authorize the Entity to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to also notify the Entity directly of the determination of such grievances or appeals.

Patient Label:

