General Consent for Admission / Treatment

General Consent and Agreement to Pay for Treatment

1. Consent for Treatment: I am entering Regional General and Vascular Surgeons (the "Facility") for medical care and treatment. I consent to my physician, other attending, consulting and/or referring physicians and their assistants, and other Facility personnel, providing me with all medical, diagnostic or other treatment services judged necessary and/or appropriate. This includes all tests, x-rays and laboratory procedures, treatments, medications monitoring and blood transfusions that do not require my separate and specific informed consent. I understand that my doctor or my doctor's designee will discuss my care and treatment options with me. I know I can refuse to consent to any procedure or treatment.

2. General Acknowledgments: I understand that the practice of medicine and surgery is not an exact science. No promise of cure or outcome of treatment has been made to me. I understand that many of the physicians who care for me in this Facility are not employees or agents of the Facility but are allowed by the Facility to provide for the care and treatment of their patients. I understand that the Facility is not liable for any acts or omissions of, or the instructions given by, such independent contractors who treat me at the Facility. I understand that it is my responsibility to follow the instructions of my care providers and to make arrangements for follow up care. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize Facility personnel to preserve or use such cells, tissues, or parts for teaching purposes and/or dispose of any cells, tissues or parts that are removed.

3. Students: I know that the Facility has agreements with education organizations. I know that students may provide care and/or observe my care. Any care I receive from students will be under the supervision of my physician and/or Facility staff.

4. Valuables: Keeping valuables in the above named Facility is strongly discouraged. I understand that the Facility has a place where my valuables can be stored. If I choose to keep my valuables with me, I do so at my own risk and the Facility is not responsible for any loss or damage to my valuables.

5. Medical Records: I understand my healthcare information will be stored, viewed and shared by my health care providers in one secure electronic medical record system. Once all my providers document my treatments and services in this shared record, I understand it cannot be separated. I agree that my medical records may be shared with my insurance carrier or its agents to obtain pre-authorization for care and to support payment of my claims or bills. This release of records may include information related to drug/alcohol abuse, mental illness, HIV and developmental disabilities. I understand my information may also be shared for collection purposes. In all cases where my medical records are released, I understand that the Facility will only share what is necessary.

6. Insurance Benefits/Agreement to Pay: I agree to pay for all charges that are due because of my care and treatment at the above named Facility. I hereby assign to Facility and the physicians and professionals associated with the Facility, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. If my account becomes delinquent, I understand that the Facility will access my credit file.

7. Medicare and Medicaid Patients: All the information I gave when I applied for Medicare/Medicaid payment is correct. I request that payment of authorized Medicare benefits be made on my behalf to the above named Facility for any services furnished to me by them. I authorize any holder of medical information about me to release to The Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

8. Photographing: I understand that the Facility may take photographic and/or video images of me in cases when it may assist with my treatment.

I HAVE READ THE ABOVE. I AGREE WITH ITS CONTENTS.

Date: ________ ________ ________ at ________________ a.m. / p.m.
Month Day Year Time

Signature ______________________________ Witness ______________________________
Patient

If the patient is a minor or unable to consent, complete and sign the following. Patient is unable to sign because:

____

____

Signature ______________________________ ______________________________
Patient's Personal Representative signing on behalf of the patient — Relationship to Patient

Witness ______________________________

AD-36-8
(3/12)