SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

CONSENT FOR MEDICAL TREATMENT ACKNOWLEDGEMENT AND ASSIGNMENT OF BENEFITS

PATIENT ID LABEL

1. **GENERAL CONSENT AND AUTHORIZATION:** I hereby authorize Saint Peter's University Hospital ("SPUH" or "Hospital"), its agents and employees and physicians on the medical staff of SPUH to provide routine diagnostic medical treatment on an inpatient and/or outpatient basis. I acknowledge that no guarantees have been made to me regarding my care and treatment at SPUH. I also voluntarily consent to HIV, hepatitis and testing for other blood and fluid borne pathogens, if a health care worker or employee is exposed to my blood or other body fluids. This consent shall also apply to the admission and medical treatment of a newborn infant(s) who deliver during my hospitalization.

2. **ACKNOWLEDGEMENT that physicians at SPUH may not be employees of SPUH:** I fully understand that many of the physicians at SPUH are neither employees nor agents of the Hospital. Many physicians are independent contractors who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. I understand that some physicians participating in my care may be employed by other academic institutions. I agree that the Hospital is not liable for the care and treatment decisions of these physicians. I understand that I have the right to request a different physician at any time.

3. **CONSENT FOR DISPOSAL OF HUMAN TISSUE:** I acknowledge the fact that the Hospital has the authority to dispose of specimens taken for laboratory or pathology examination. I permit the Hospital to examine, dispose of or keep for scientific, teaching or other purposes any specimen or tissue that may be removed from my body.

4. **CONSENT FOR OBSERVATION OR ASSISTANCE:** I understand that the Hospital is a teaching hospital and is affiliated with other academic institutions. I consent that fellows, residents, interns, medical and nursing students and other healthcare professional students to observe or assist in my care and treatment under the supervision of the Hospital staff and my physician.

5. **USE AND DISCLOSURE OF INFORMATION:** I understand that SPUH is a participant in the Jersey Health Connect health information exchange network, and that unless I follow the procedure to opt-out, I authorize SPUH and Jersey Health Connect to share my health information, including Protected Categories of Health Information, to all individuals and entities who are authorized to access such information for purposes related to my treatment. Protected Categories of Health Information include: any and all information related to a diagnosis of HIV/AIDS, sexually transmitted diseases, mental health records, drug and alcohol treatment information, and genetic information.

6. **CONSENT TO BE PHOTOGRAPHED, RECORDED OR FILMED:** I permit the Hospital to photograph, film or video tape operations or procedures showing portions of my body for medical, scientific or educational purposes, provided my identity is not revealed.

7. **RELEASE OF MEDICAL INFORMATION:** I authorize the Hospital and/or physicians participating in my care to release (either verbally or in writing) any medical information which may be needed to assist in my continued care plan or may be needed to process claims for medical insurance benefits relative to this hospitalization. I understand that my treatment providers will access my prior hospital medical records to aid in treatment. I also understand that if I am to receive a specific implanted medical device, the Hospital will release my social security number to the manufacturer of the device for identification purposes. Federal law requires that Medical Device Tracking be done for certain devices.

8. **RELEASE OF LIABILITY FOR PERSONAL VALUABLES/PROPERTY:** I understand that the Hospital recommends that all personal belongings and valuables should be sent home with a family member or friend. I assume all risk for the loss or damage of any personal property that I keep. I understand that SPUH is not responsible for the security or loss of patient personal belongings.

9. **FINANCIAL ARRANGEMENTS: I understand that the hospital charges do not include the fees of my treating physicians, including the emergency room physicians, radiologists, anesthesiologists, pathologists or other hospital based physician providers and that I will receive a separate bill for these services.**

- If appropriate, I have been given a copy of "An Important Message from Medicare" and/or "Notice of Charity Care and Reduced Charge Charity Care" and I understand my rights as outlined in the document. If admitted as an inpatient, I have received a copy of the Hospital's "Patient Rights and Responsibilities" booklet and the Notice of Privacy Practices.

- I understand that I am financially responsible for the payment of medical fees to the hospital and physicians. I authorize payment of health insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to the hospital and/or physician(s) participating in my care. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid and its agent any information needed to determine these benefits for related services.
- I agree to pay for charges not covered or approved by my health insurance company or managed care organization. I agree to pay any applicable health insurance deductibles, co-payments and/or co-insurance. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries and it is my responsibility to obtain appropriate pre-approval.
- I understand that the Hospital will not deny emergent treatment and/or admission based on the patient's ability to pay.
- I understand that the physician/specialty offices are "Hospital-Based Outpatient" offices and receiving care at one of these areas may result in a hospital charge, as well as a physician charge for outpatient services and/or procedures. I also understand that it is my responsibility to determine what my insurance will cover and identify any out-of-pocket expenses.

I have read and understood this Consent for Medical Treatment, Acknowledgement and Assignment of benefits. I have signed this document voluntarily and of my own free will. I agree that any questions I may have, have been answered.

____________________________ ____________________
Signature of Patient | Date | Time

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Print Name of Patient

____________________________ ____________________
Signature of Person Signing on Behalf of Patient | Date | Rel to Patient

____________________________ ____________________
Signature of Responsible Party (if different from Patient) | Date | Rel to Patient

____________________________ ____________________
Print Name of Person Signing Above | Reason for Signature

____________________________ ____________________
Witness | Date | Time