HAR # _____

MRN # _____

THE CHRIST HOSPITAL
CINCINNATI, OHIO 45219
CONSENT FOR HOSPITAL AND MEDICAL TREATMENT

Name: _____

Date: _____ Time:_____am/pm

1. **CONSENT TO TREATMENT:** I hereby consent to the administration of medical, nursing or other treatment, drug therapy and/or testing as considered necessary for my condition as directed by Dr. _____and his/her associates or assistants as may be needed. I understand that The Christ Hospital is a teaching hospital and agree that interns, residents, fellows, nurses, medical students and other health personnel in training may participate with or assist my doctor(s) in the performance of medical, surgical or diagnostic procedures/treatment that my doctor(s) consider necessary.

2. **RELEASE AND USE OF RECORDS:** I authorize the release of medical records information (including, but not limited to information concerning drug related conditions, alcoholism, psychiatric conditions, HIV testing, AIDS diagnosis/related conditions) to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided. I authorize the release of medical record information to the physician(s) or agency responsible for my follow-up care, and/or to the healthcare facility to which I am transferred from The Christ Hospital. I authorize The Christ Hospital to access, release, and share accessible electronic medical information with other medical providers who utilize an electronic medical record system compatible with The Christ Hospital system. I authorize release of my medical record information as required or permitted by state or federal law including, but not limited to, for purposes of obtaining payment.. Lastly, I understand my records may be released to state, federal, or other surveyors for accreditation and/or regulatory licensing purposes.

3. **NOTICE:** I understand that certain physicians providing services to me, including Emergency Room physicians, anesthesiologists, radiologists, and pathologists are independent contractors not employed by the hospital, and that I will be billed by the individual physician for services rendered to me by these physicians.

4. **MOTHER/NEWBORN ONLY:** I give permission to The Christ Hospital and my physician(s) to care for my newborn prior to discharge. I understand that if I have not chosen a physician for my newborn, or if my newborn's chosen physician is unavailable or not on The Christ Hospital Medical Staff, I permit a physician on staff at The Christ Hospital to attend to my newborn prior to discharge.

NOTICE: Medical records of The Christ Hospital are kept on file for ten (10) years and then destroyed. You have a right to inspect and obtain a copy of your medical record. There will be a charge for this service.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are legally required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICES** the first time you receive care at The Christ Hospital. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

Patient or Patient's Legal Representative please check the appropriate box and sign below:

Notice of Privacy Practices ☐ I have received a copy ☐ I have previously received a copy ☐ I do not want a copy

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FINANCIAL AGREEMENT

1. The undersigned agrees that, in consideration of the services to be rendered to the patient, he/she will pay the amount of the hospital bill and any physician charges in accordance with their regular rates and terms.
2. The undersigned agrees to release "The Christ Hospital" from any responsibility or liability arising from the loss or damage to personal items or valuables brought to the hospital.
3. Pursuant to Section 3727.12 of the Ohio Revised Code the undersigned is entitled, upon request, to a list of the usual and customary charges for room and board and the usual and customary charges for a selected number of x-ray, laboratory, emergency room, operating room, delivery room, physical therapy, occupational therapy and respiratory therapy services. If you would like a copy of the charge list, please call Customer Service at 585-1600.
4. The undersigned understands that Medicare and Medicaid are payers of last resort and The Christ Hospital may choose not to bill those payer sources if a third party is liable to pay for his/her treatment.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to The Christ Hospital and/or my physician(s) and/or their designees, all Medicare benefits, other insurance benefits, or other payments from any payer liable by reason of contract or negligent or wrongful conduct, otherwise payable to me.

Did you receive "Important Message from Medicare?" ☐ **Yes** ☐ **No** ☐ **N/A (Not Applicable)**

Private Rooms are provided whenever possible, but are not always available and cannot be guaranteed in advance. Private rooms are assigned based on medical necessity first, and then by request.

Private room is available and I am responsible for $_____.

(Other accommodations at $_____ per day).

I am requesting a telephone. ☐ **Yes** ☐ **No**

ADVANCED DIRECTIVES
Living Will/ Durable Power of Attorney for Healthcare

Do you have:			
Living Will	☐ **Yes**	☐ **No**	☐ **Copy Received**
Durable Power of Attorney for Healthcare	☐ **Yes**	☐ **No**	☐ **Copy Received**
Do Not Resuscitate Comfort Care (DNRCC)	☐ **Yes**	☐ **No**	☐ **Copy Received**
Do Not Resuscitate Comfort Care Arrest (DNRCCA)	☐ **Yes**	☐ **No**	☐ **Copy Received**
Patient/Family Advised to Bring Copy to Hospital	☐ **Yes**	☐ **No**	
Information Provided	☐ **Yes**	☐ **No**	
Do You Need More Information	☐ **Yes**	☐ **No**	
Patient Declined Assistance with Execution of Advance Directives at this time	☐ **Yes**	☐ **No**	
Psychiatric Advance Directives	☐ **Yes**	☐ **No**	

Patient's Signature:_____ **Date & Time:**_____

Patient is unable to consent because: _____
or
Patient is unable to consent because he/she is a minor: _____ (indicate years of age)

Closest Relative or Legal Guardian:_____**Relationship:**_____

Witness: _____ **Date & Time:** _____

For The Christ Hospital staff: use only if patient or patient's legal representative has not acknowledged above.

Patient or Patient's Legal Representative has:

☐ Refused to sign Acknowledgment ☐ Unable to sign Acknowledgment ☐ Previously acknowledged receipt

Witness: _____ **Date & Time:** _____

The Christ Hospital recognizes that the decision to make an advanced directive is voluntary and that no discrimination in the rendering of care will occur based upon whether or not a patient has completed an advanced directive.

Was interpreter services used:_____

If yes, who: _____

Language: _____