UNIVERSITY MEDICAL CENTER
NEW JERSEY

OUTPATIENT CONSENT FORM

Addressograph

Patient Name: _____

1. **CONSENT TO CARE:** I wish to be treated by and/or admitted to **University Medical Center.** While I am a patient, I give permission to my doctor(s), the hospital employees, and all the persons caring for me to provide care in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatments. I understand that the Medical Center is a teaching hospital and that under the appropriate supervision medical students, fellows and residents of the University of Medicine and Dentistry of New Jersey, University Medical Center, or other teaching affiliates may participate in my care and treatment. The University of Medicine and Dentistry of New Jersey medical students, fellows and residents are employees of the state of New Jersey. I understand that no guarantees have been made to me about the outcome of this care. I hereby authorize University Medical Center to preserve and use for scientific and/or teaching purposes, or dispose of any specimens or tissues taken from my body during hospitalization.

2. **RELEASE OF INFORMATION:** The Medical Center may see, release to and/or confirm, all or part of any financial and medical information, **including information regarding psychological, psychiatric, HIV and related diagnoses, drug and/or alcohol related illness,** with any person, corporation or government agency that is or may be responsible to the hospital, the patient, and family member or employer for all or part of the Medical Center's charges or verification of same. I acknowledge that the Medical Center may verify my address through a database search of the Federal Credit Reporting System. I acknowledge that the Medical Center may be required to release patient information, **including the highlighted above,** to federal and state agencies that monitor healthcare facilities, as well as any industries that produce and/or manufacture medical products. I authorize the Medical Center provide access to my medical information to any person or organization in order to facilitate the provision of post hospital care, treatment or services. I acknowledge that the Medical Center may access patient information from my medical record for purposes of research. I acknowledge that I have been informed that I may be contacted to participate in a research study and that I have the right to agree or decline to participate.

3. **PATIENT RIGHTS:** I acknowledge that I have received a copy of the New Jersey Patient Bill of Rights and an Advance Directive Brochure.

   ADVANCE DIRECTIVE: Federal and State law requires hospitals to ask the following questions of all adult patients being registered to their facility. Do you have an Advance Directive or Living Will for healthcare?

   ❑ Yes ❑ No ❑ N/A Name of Healthcare Proxy (if Applicable) _____

   Was a copy of the document provided at the time of registration? ❑ Yes ❑ No

_____ _____ _____ _____
Patient Date Guarantor (if other than Patient) Date

_____ _____ _____
Witness Date Relationship of Guarantor to Patient, if applicable

1. **PRE-CERTIFICATION REQUIREMENTS:** I understand that if I do not comply with my insurance policy pre-certification requirements or if any service is not certified, that I may be responsible for any and all hospital charges.

   Please check the appropriate box: (Pre-Certification)
   I acknowledge that the pre-certification requirements I am responsible for have all been met.

   ❑ Yes ❑ No ❑ Not Applicable

2. **ASSIGNMENT OF BENEFITS:** I authorize my health insurance benefits to be paid directly to **UNIVERSITY MEDICAL CENTER.** Under the terms of my policy this payment may not exceed the balance due for services performed during this period of treatment. I further authorize University Medical Center to appeal on my behalf any denial of claims by my insurance carrier.

3. **FINANCIAL AGREEMENT:** If billed, I agree to make prompt payment to University Medical Center.

4. **PAYMENT REQUEST:** A payment has been requested of me because I will be paying for all and/or part of the hospital bill.

5. **NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM:** I have received a copy of the notice of New Jersey hospital care assistance program.

6. **MEDICARE PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physicians services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

7. **OUTPATIENT SERVICE "MEDICAID":** I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for hospital services to the University Medical Center and the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

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I have read the information contained above, any questions I had have been answered, and I understand its contents. I attest that my personal information provided to University Medical Center is correct. I understand that providing incorrect information for the purpose of avoiding payment or for any other reason may be considered a violation of state and/or federal law.

Patients objecting to any statement in the Consent Form may put a line through that statement and initial it. This action indicates that the patient is deleting this statement and that their signature does not indicate consent or acknowledge of that item. However, patients cannot delete paragraph number 1 which is the consent for treatment or items relating to their financial responsibility.

_____ _____ _____ _____
Patient Date Guarantor (if other than Patient) Date

_____ _____ _____
Witness Date Relationship of Guarantor to Patient, if applicable