Memorial Hospital

DATE

EVIDENCE OF AGREEMENT TO OPERATE

CERTIFICATION OF THE OBTAINING OF INFORMED CONSENT FOR THE PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

PERMISSION FOR SURGERY AND INVASIVE PROCEDURES

I hereby certify that I have discussed the following procedure(s) with patient. (1) _____

or their parent, legal guardian, or family (if applicable) (2) _____

(Identify the procedure(s) to be performed; specify any limitations requested by the patient) (3) _____

_____

_____

The above named patient, legal guardian, or nearest relative, as appropriate, has requested that the named procedure(s) be performed by Dr. (s) (4) _____ and other doctors of my (our) choice who may be required.

(5) Site of Operation: _____ ☐ Left ☐ Right ☐ NA

PERMISSION FOR NECESSARY ADDITIONAL PROCEDURES

The named patient has also given their permission for the performance of additional procedures or the administration of blood products that are considered necessary on the basis of findings during the course of the original operation except for any limitations specified above.

AUTHORIZATION FOR DISPOSAL OF TISSUE AND SPECIMENS

The named patient has also authorized Union Memorial Hospital to retain, photograph, preserve, dispose at their convenience, or use for scientific teaching purposes, any specimens or tissue taken from the patient during the operation. Authorization is also granted to take videos / photographs of the procedure(s) for teaching.

AUTHORIZATION TO BE CONTACTED

The named patient has also given permission to be contacted by the research staff of the Union Memorial Hospital for the purpose of potential participation in approved clinical research or outcomes based research studies carried out by Union Memorial Hospital under the direction of the teaching faculty. I understand that I can withdraw this permission at any time, and that no future communications will be sent to me after I withdraw the permission.

DISCUSSION OF REQUIRED INFORMATION

I further certify that I have discussed the following with the patient named above:

1) The nature of the ailment which has led to the need for surgery;
2) The nature and benefit of the proposed procedure(s) named above;
3) Alternative methods of treating the ailment.
4) The risks involved in each method of treatment; and
5) The known consequences or complications which will or may result from each method of treatment.
6) Other _____

CERTIFICATION

I hereby certify that I have discussed all the above with the named patient and have secured their permission and consent as outlined above.

Signature of Physician Securing the Patient's Consent _____

Date _____

I acknowledge that Dr. _____ (or his designee) has informed me of the risks and benefits of and the alternatives to this procedure.

Patient Signature (or designee) _____

ADDITIONAL NOTATION (IF ANY)

_____

_____

Memorial Hospital

DATE

CONSENT FOR MEDICAL TREATMENT - A

ONSENT FOR MEDICAL TREATMENT: I hereby authorize the personnel of this hospital and members of its medical staff to render to the patient whose name ppears on this form care as they deem necessary and appropriate.

UTHORIZATION TO RELEASE INFORMATION: I hereby authorize this hospital to release my final diagnosis and other medical information to the third parties entified to determine benefits payable.

HYSICIAN CHARGES: I understand that in addition to any bills I may receive pertaining to facility (hospital) charges, I may also receive bills on behalf of the hysicians who participate in my care. These physician charges are not included in the bill from the hospital. (Note: when verifying your insurance coverage for our hospital stay, please verify your coverage for the physician groups that may contribute to your care.)

SSIGNMENT OF BENEFITS: I hereby authorize direct payment of this hospital of any insurance, personal injury or other benefits otherwise payable to me or e patient. The undersigned acknowledges the responsibility for any coinsurance, deductible or other sum not received by the hospital from any third party ource.

UARANTEE OF PAYMENT: I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance rrier to pay the hospital's charges in full when rendered. I also acknowledge that interest may be charged to unpaid balances over thirty days from the date ayment is due. In the event that the account is referred to collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent alance.

ATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (applies to Medicare Patient Only) I hereby certify that the information given / me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payors is correct. I authorize any holder of medical or other formation about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I ereby authorize this hospital to use my sixty (60) Lifetime reserve days Medicare coverage. I have received ***An Important Message From Medicare*** (inpatients nly).

ERSONAL VALUABLES: Patients are encouraged to leave all money and valuables at home. The hospital shall not be responsible for the loss of or damage to ny personal property the patient has brought into the hospital inclusive of dentures and glasses.

ATIENT RIGHTS AND RESPONSIBILITIES: I have received information about Patient Rights and Responsibilities.

OTICE OF PRIVACY PRACTICES: My initials acknowledge that I am in receipt of the MedStar Privacy Practices Brochure: _____ *Initials*

UTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION TO THE MARYLAND INSURANCE ADMINISTRATION. Under Maryland law, I have the ght to contest a decision by an HMO or insurer that a proposed or delivered health care service was not medically necessary. The law allows the Health dvocacy Unit of the Attorney General to assist me in filing an internal grievance with the HMO or insurer and allows me to externally appeal the final decision to e Maryland Insurance Administration. A health care provider may also file an internal grievance or external appeal on my behalf. I authorize a health care rovider to file such a grievance or appeal. Maryland law permits the Insurance Administration to receive advice from medical experts or Independent Review rganizations while determining whether to uphold or overturn the HMO or insurer's decision that a health care service was not medically necessary. Throughout ie grievance or appeal process, the confidentiality of my medical records will be maintained in accordance with Maryland and Federal law. I understand that if I ave questions about the contents of my medical records to be released, I should contact my health care provider. In the event I, or a provider on my behalf, files grievance or an appeal, I authorize the release of medical records to the Health Advocacy Unit of the Attorney General and the Maryland Insurance dministration as follows: (1) I authorize the Attorney General and the Insurance Administration to obtain medical records and Insurance information related to my omplaint or appeal, (2) I also release any medical records obtained on my behalf to the Attorney General, (3) I further authorize the Maryland Insurance dministration to release my medical records to medical experts who may assist the Maryland Insurance Administration with my appeal. I understand that my ecords may be used to develop general statistical information on my complaints and appeals filed, and any statistical reports will not identify me or contain any lentifying information. I am not authorizing the release of any information that would identify me to anyone not mentioned above. This authorization is valid for a eriod not to exceed twelve (12) months from the date of my signature below.

CERTIFY THAT 1) I UNDERSTAND THE CONTENTS OF THIS FORM AND 2) ALL INFORMATION GIVEN THE HOSPITAL, INCLUSIVE OF INSURANCE NFORMATION IS ACCURATE AND CORRECT. A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

Signature (Seal) _____ Date _____

Patient Name (Please Print) _____ Witness _____

Authorized Person's Signature _____ Relationship to Patient _____

Reason patient unable to sign (check one): ☐ Minor ☐ Condition