



CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

I. CONSENT FOR MEDICAL PROCEDURES AND TREATMENT: Permission is hereby granted to Cogdell Memorial Hospital / Cogdell Family Clinic for such medical procedures, including the taking of photographs for treatment purposes only, as may be deemed necessary by my physician and/or his or her designee. It is also, an understood consent for all registrations directly associated to the care on this date of service. Certain procedures require a separate Consent signature. I recognize and acknowledge that the physicians that provide care at Cogdell Memorial Hospital are not agents, servant, or employees of the Hospital. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations, emergency services, or hospital care.

II. CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING: I hereby give my consent to have testing for blood-borne infectious disease, including, but not limited to Hepatitis, Acquired immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV) if a physician orders such test(s) or if ordered by protocol. The potential side effects of this testing are those encountered during the routine procedure of obtaining blood specimens. The minor complications may include discomfort from the needle stick and slight burning, bleeding or soreness at the site where blood was obtained. The results of this test will become a part of my confidential medical record. I understand that refusal to consent will not result in denial of admission to this Hospital.

III. CONSENT FOR EMERGENCY TREATMENT: I believe that I am suffering from an emergency medical condition. I know this condition entitles me to an appropriate medical screening and treatment necessary to stabilize an emergency medical condition, regardless of my ability to pay. I therefore authorize the Hospital to provide an appropriate medical screening evaluation and treatment, to be performed by or under the supervision of a physician or his/her aide. It has been explained to me that the diagnostic and treatment procedures, which my emergency medical condition legally entitles me, are limited and will include a medical screening examination. It may be necessary for me to select another physician and obtain from him/her a complete diagnosis of my condition and such continued treatment as he/she may prescribe.

IV. ACKNOWLEDGMENT OF ADVANCE DIRECTIVE, LIVING WILL AND PATIENT HANDBOOK: I have been offered Advanced Directive and Living Will information and have been informed that it will be given to me at any time at my request during my hospital visit. Patient Rights and Responsibilities and other information relating to my stay are available to me in Patient Registration.

Do you have an Advance Directive? [] Yes [] No
Medical Power of Attorney? [] Yes [] No

V. CONSENT TO DISCLOSE PATIENT INFORMATION AND OPT OUT OF THE FACILITY DIRECTORY: The Hospital will not divulge any identifying information about patients without their consent. With this in mind, we need your permission to release information about your presence at the Hospital during your stay. By choosing to opt out of the Facility directory, your location in the hospital will not be released. In addition, you will not receive flowers, cards, phone calls or clergy visits.

I wish to be a NO INFORMATION patient. [] Yes [] No

DOB: AGE: HSV:
ADMIT: SEX:
MR #: PAT #:



VI. CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS: I consent to the use or disclosure of my protected health information by Cogdell Memorial Hospital/CMH for the purpose of diagnosing or providing treatment to me obtaining payment for my health care bills, or to conduct health care operations of the CMH. I understand that diagnosis or treatment of me by the CMH may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the Hospital. CMH is not required to agree to the restrictions that I may request. However, if the CMH agrees to a restriction that I request, the restriction is binding on CMH.

I have the right to revoke this consent, in writing, at any time, except to the extent that Cogdell Memorial Hospital has taken actions in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physician or mental health or condition and identifies me, or there is a reasonable basis to believe the Information may identify me. I understand that I have a right to review CMH Notice of Privacy Practices prior to signing this document. CMH Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of CMH. The Notice of Privacy Practices for Cogdell Memorial Hospital is also posted in the Main Lobby. This Notice of Privacy Practices also describes my rights and CMH's duties with respect to my protected health information.

CMH reserves the right to change the privacy practices that are described in the Notice of Practices. I may obtain a revised Notice of Privacy Practices and Patient Rights and Responsibilities by calling the Admitting Department at 325-573-6374, or by requesting a revised copy be sent to me in the mail.

VII. RELEASE OF INFORMATION: I authorize the Hospital and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this admission or outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work-related, I authorize the Hospital to release any information from my medical records to my employer and/or its designee. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood borne. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses and technicians at the Hospital, home health agencies, ambulance companies, and such other health care agencies involved in my care during and after transfer or discharge from the Hospital. I further acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes and studies. I also acknowledge that my medical records will also be made available to government agencies as required by law. Information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel, as well as physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility in the area affiliated with the Hospital, my medical records may be made electronically available to the other facility, as well as physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device I may receive.

VIII. ASSIGNMENT OF BENEFITS: This assignment of benefits allows the Hospital and/or hospital based physicians to be paid directly by my health insurance carrier or other health benefit plan for the services the Hospital and/or hospital based physicians provide to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital based physicians, I hereby irrevocably assign and transfer to the Hospital and/or hospital based physicians all right, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Hospital and/or hospital based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Hospital and/or hospital based physicians to pursue any such right of recovery. In no event will the Hospital and/or hospital based physicians retain benefits in excess of the amount owed to the Hospital and/or hospital based physicians for the care and treatment rendered during this admission. I have read and been given the opportunity to ask questions about this agreement of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Hospital and/or hospital based physicians.



