

1. **CONSENT FOR TREATMENT**

I hereby consent to the administration and performance of such medical treatments and diagnostic procedures as may be deemed advisable during the course of my hospitalization by my attending physician / emergency physician or his / her designee(s).

I understand that the Hospital is an institution which provides clinical training opportunities for medical, nursing, and allied health students. These training programs are provided by the Hospital solely and/or in cooperation with other institutions. I understand that the treatment and care provided me at Kishwaukee Community Hospital/Valley West Community Hospital may involve one or more students functioning under the direct supervision of my physician(s) and/or duly authorized designee(s) or the registered nurses and therapists assigned to my care.

2. **RELEASE OF INFORMATION**

I hereby authorize Kishwaukee Community Hospital/Valley West Community Hospital to release to my insurance companies, employer insurance groups, health plans, Medicaid / Medicare program, its insurance carriers or intermediaries, and authorized external review agencies, any medical records or other information concerning this treatment, including this patient authorization record, to process insurance claims and conduct utilization review procedures.

3. **PHYSICIAN SERVICES**

I understand that I am financially responsible for the professional services of radiologist(s), pathologist(s), anesthesiologist(s), and other physician charges which are not billed by the hospital. **Physicians providing care are independent practitioners and are not employees or agents of Kishwaukee Community Hospital/Valley West Community Hospital.** I hereby authorize my third party payor to directly pay the above named parties or their service corporation. I hereby authorize release of information requested by insurance / billing agencies to the above named parties. _____ (patient initials)

4. **MEDICARE**

If I am an inpatient Medicare beneficiary, my signature only acknowledges that I have received a copy of "An Important Message from Medicare" from Kishwaukee Community Hospital/Valley West Community Hospital and does not waive any of my rights to request a review or make me liable for any payments. If I wish to exercise my right to request a review by the PRO, I must have a "Notice of Noncoverage".

5. **FINANCIAL AGREEMENT AND PAYMENT GUARANTEE**

I hereby assign Kishwaukee Community Hospital/Valley West Community Hospital all of my rights and claims for reimbursement under any Medicare, Medicaid, or other insurance policies for which benefits may be available for payment of services provided. I agree to pay Kishwaukee Community Hospital/Valley West Community Hospital the balance due of all charges not paid for by the above-mentioned coverage (excluding those charges not collectible pursuant to Medicare regulations). This may include the cost of collection and / or reasonable attorney's fees.

I have been made aware that information about the billing and payment policies is located in the Patient Guide.

6. **PRIVATE ROOM (Inpatients Only)**

If I select a private room, I understand that I will be responsible for the difference between the semi-private and private rate, unless medically necessary.

7. **RELEASE FROM RESPONSIBILITIES FOR VALUABLES**

I understand that the hospital does not assume responsibility for personal possessions that are not placed in the hospital safe.

8. **NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the Notice of Privacy Practices from Kishwaukee Community Hospital/Valley West Community Hospital either today or since April 14, 2003 that provides a complete description of how my health information is used and shared.

Signed _____ Date _____

Relationship _____ Witness: _____

If signed by other than patient or patient consent unable to be obtained, check reason:

Patient non-responsive Patient confused/disoriented Patient has been sedated Other: _____

LABEL:

KISHWAUKEE HEALTH SYSTEM

Kishwaukee Community Hospital & Valley West
Community Hospital [7/05 Re-created as KHS, see
archives for prior policy information, 9/06]
KHS6000\ptcareclinical\pp\patientauthorizationrecord+ pg 1 of 1

PATIENT AUTHORIZATION RECORD

Inpatient / Outpatient