

GENERAL POLICY: All patients shall be treated, admitted and assigned accommodation without distinction to race, religion, color, national origin, sexual orientation, age or handicapping condition.

CONSENT TO TREATMENT: I have come to The George Washington University Hospital for medical treatment. I ask the health care professionals at the Hospital to provide care and treatment for me that they feel is necessary. The undersigned consents to the procedures, which may be performed during this hospitalization, or on an outpatient basis including emergency treatment or services. I consent to undergo routine tests and treatment as part of this care. These may include but are not limited to laboratory, radiology, medical or surgical tests, treatments, anesthesia or procedures as directed under the general and special instruction of the physician or surgeon. I understand that I am free to ask a member of my health care team questions about any care, treatment or medicine I am to receive. Because The George Washington University Hospital is a teaching hospital, I understand that my health care team will be made up of hospital personnel (to include nurses, technicians, and ancillary staff) under the direction of my attending physician and his/her assistants and designees (to include interns, residents, fellows and medical students). I am aware that the practice of medicine is not an exact science and admit that no one has given me any promises or guarantees about the result of any care or treatment I am to receive or examinations I am to undergo.

PHYSICIANS NOT AS EMPLOYEES: I understand that each physician is an independent contractor who is self employed and is not the agent, servant or employee of the hospital. I understand that I may receive separate billing from each of these providers for services rendered. _____ Initials

RELEASE OF INFORMATION: The George Washington University Hospital is authorized to release any information necessary, including copies of my hospital and medical records, to process payment claims for health care services which have been provided, and to duly authorized local and federal regulatory agencies and accrediting bodies as required or permitted by law. George Washington University Hospital is further authorized to release demographic information to organizations performing patient satisfaction surveys. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide The George Washington University Hospital information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by myself. I release and forever discharge The George Washington University Hospital, its employees and agents, and my attending physician from any liability resulting from the release of my medical records or information from them for payment purposes. I understand that my name will be displayed in the signage system outside my hospital room.

PERSONAL VALUABLES: THE GEORGE WASHINGTON UNIVERSITY HOSPITAL WILL NOT BE RESPONSIBLE FOR LOSS OR DAMAGE TO CLOTHES, PERSONAL PROPERTY OR VALUABLES.

NON-SMOKING POLICY: In accordance with regulatory agency standards, the Hospital is a non-smoking facility.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I assign any and all insurance benefits payable to me to The George Washington University Hospital. I understand that I am responsible for payment for services rendered at the Hospital including excluded services from my insurance either because the plan deems such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or preexisting conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney or collection expenses. I give permission to my insurance provider(s), including Medicare and Medicaid, to directly pay The George Washington University Hospital for my care instead of paying me. I understand that I am responsible for any health insurance deductibles and co-insurance and non-covered services.

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information that I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and other as required, I authorize my employer to release to The George Washington University Hospital proof of my income. I understand that if any information I have given proves to be untrue, The George Washington University Hospital will re-evaluate my financial status and take whatever action becomes appropriate. I acknowledge by my signature that I have read and received a copy of this statement. I understand that by signing it, I am agreeing to it.

X _____
Signature of patient or responsible party

Unable to sign
() Serious Condition
() _____

Date Witness

Hospital Representative _____
Date

Section 1:

Did you bring an Advance Directive (Living Will/Health Care Power of Attorney) form with you?

Yes No

(If YES, place a copy in the front of the patient's chart / If NO, go to Section 2)

Section 2:

1. I was given information on formulating an Advance Directive (including how to obtain assistance with completing the Advance Directive form). _____ initials
OR

2. I do not have an Advance Directive and do not wish to formulate one. _____ initials

By my signature below, I consent to laboratory studies (HIV, HBV, HCV) in the event a health care worker is exposed to my blood or body fluids. I also agree to the disposal or use of any tissue or part removed from my body and/or to the taking of photographs during my treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

Signature _____ Date _____

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL



Patient Label



CO0010

PATIENT AUTHORIZATION FORM

80-010 (7/06)

WHITE - MEDICAL RECORD YELLOW - BUSINESS OFFICE PINK - PATIENT COPY

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