Essentia Health

GENERAL CONSENT AND AUTHORIZATION

In order for Essentia Health to treat you, we ask you to sign below indicating your consent to treatment:

A. I give my consent to Essentia Health doctors and healthcare workers to perform exams, treatments, x-rays, lab tests and operations, and to give me medicine that they believe is necessary or helpful to my health.

B. I understand that while I am receiving care, a healthcare worker may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become part of my medical record and will be released to the exposed healthcare worker and a positive result must be reported to the state by law.

C. I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to Essentia Health for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds. I further agree to pay reasonable attorney fees and all costs of collection in the event my account is turned over to an attorney or collection agency. I understand that it is my responsibility, not Essentia Health's, to negotiate for payment of a claim that is disputed by the payer.

E. A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been given to me.

F. I request that payment of authorized Medicare benefits be made on my behalf to Essentia Health for any services furnished me by an Essentia Health provider and/or in an Essentia Health facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

G. I request that payment of authorized MediGap (supplemental insurance) benefits be made on my behalf to Essentia Health for any services furnished to me by an Essentia Health provider and/or in an Essentia Health facility. I authorize any holder of medical or other information about me to release to my MediGap carrier any information needed to determine these benefits or benefits for related services.

H. I authorize Essentia Health to utilize my 60 lifetime reserve days as necessary after expiration of regular Medicare Benefits. I understand if reserve benefits are used, there will be co-insurance due, and once used they are permanently reduced by the number of days used.

I. I consent for medical photographs to be made of me (or the person for whom I am legal guardian). I understand that the information may be used in my medical record, and/or for purposes of medical teaching. Refusal to consent to photographs will in no way affect the medical care I will receive.

J. I acknowledge and understand I am responsible for my personal valuables (including money, jewelry, dentures, hearing aides, eyeglasses, etc.) while a patient at Essentia Health. While a patient, I have been encouraged to send all personal items of value home with relatives or friends. I also acknowledge I have been informed of the availability of safekeeping for my personal valuables. I release Essentia Health from any liability for loss by theft or negligence of mine or any hospital employee of my personal valuables.

Essentia Health respects your right to privacy. Under the following conditions your health information will only be released with your consent:

K. I authorize Essentia Health to release my medical records to, and as needed, to discuss my care with my doctors, other healthcare providers, and anyone else Essentia Health either believes to be involved in, or who may participate in my care, treatment, case management and/or discharge planning. This includes source documents (such as x-rays). I authorize Essentia Health to electronically release my protected health information to other healthcare providers involved in my care and treatment and who share electronic medical record systems with Essentia Health. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other: _____
(Please specify relationship to patient)

_____ ____/____/____ _____
Signature (Patient or Authorized Representative) Date Time

_____
Witness (signature by mark must be witnessed)

_____
Patient Name & Medical Record Number
OR
Patient Label

CON.016 Orig. 7/04; Rev. 7/05, 3/07, 11/07, 1/08, 11/08, 1/09, 7/09, 01/11, 04/11, 09/11; 3/12; 01/13, 11/14 **Original:** Medical Record **Copy**: Patient
Caduceus#: 52570 Lawson#: 52570

L. To improve the coordination of my care, I authorize Essentia Health to electronically release my protected health information to other healthcare providers involved in my care and treatment and who participate in local, state and/or national Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

M. I authorize Essentia Health to release my protected health information to insurance companies, government programs, and other parties who are responsible for, or who facilitate, payment of my bill, fraud investigation, care management, or quality improvement. This includes behavioral health and chemical dependency information. Essentia Health may also release my protected health information to suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer. I also authorize Essentia Health to release my protected health information to organ procurement organizations to facilitate donations, and to e-Prescribing networks to facilitate prescription management.

N. I authorize Essentia Health to release information from my medical records: as needed by the Federal Food and Drug Administration (FDA) or manufacturers of drugs or medical devices to contact me about defects or recalls; or to emergency service providers involved in my care before and during transport to Essentia Health, for quality improvement.

O. I authorize Essentia Health to release information from my medical records and source data as needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to physician specialty boards for board certification/re-certification of physicians.

P. I authorize Essentia Health to release information from my medical and billing records for scientific and health services research to improve patient care and delivery. I may object at any time to release of my protected health information for scientific research.

Q. If I have agreed to participate in Guarantor Billing, I authorize my bill to be combined into one statement that, as applicable, covers my current spouse and minor children with the same mailing address. This statement will be sent to the guarantor listed on my account. The combined billing statement will include patient name, the date of service, the location of service, a brief summary of the services received (including type/name of diagnostic tests) and the amount due. I authorize Essentia Health to discuss billing or payment-related issues with the listed guarantor who provides my name, address, date of birth, and my Essentia Health account number(s) for the dates of service to which this authorization applies, as well as his or her own name and address.

R. I authorize Essentia Health to disclose my presence and religious preference to Essentia Health Chaplains and to clergy of my denomination, and to disclose my presence to foundations that support Essentia Health and its mission. I understand that Essentia Health will ask specific permission before disclosing my presence for behavioral health or chemical dependency services.

S. I agree to the presence of students, observers from other healthcare facilities, healthcare consultants and approved representatives of medical service providers during tests, exams, medical treatments and other services at Essentia Health. I understand that Essentia Health will also seek my oral permission to have non-Essentia Health persons present during any services.

T. I authorize my health insurance plan to release to Essentia Health my protected health information about services I have received from Essentia Health and other care providers unrelated to Essentia Health. Essentia Health may use this information for treatment, payment, operations and case management purposes.

U. When consent is required under applicable state law, I authorize Essentia Health to access my current prescription history of regulated controlled substances in any applicable state databases (such as Minnesota's RxSentry PMP database).

V. I understand that this authorization ends one (1) year from the date signed except for purposes of payment and research.

W. If this is my first visit to this Essentia Health location, I acknowledge that a copy of the current Notice of Privacy Practices has been provided to me and is available to me via postings in the registration areas and on the website www.essentiahealth.org. I understand that I can ask for a copy of the notice at any time.

- I understand that I may revoke this permission at any time by notifying Essentia Health in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from Essentia Health.
- I understand that Essentia Health will treat me whether or not I consent to sections L-M and O-S of this document.
- I understand I will receive a copy of this form.
- For care provided in Wisconsin: I understand Wisconsin law gives me the right to inspect and receive a copy of behavioral health and chemical dependency information to be disclosed.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other:_____
(Please specify relationship to patient)

_____ ____/____/____ _____
Signature (Patient or Authorized Representative) Date Time

_____
Witness (signature by mark must be witnessed)

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Patient Name & Medical Record Number
OR
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