Provider ID Group #: _____ Primary Coverage Member ID: _____

Secondary Coverage Member ID: _____

CONSENT FOR TREATMENT:

- I consent to receiving care at this Facility which is necessary or beneficial, including, but not limited to, the administration of medications, injections, x–ray examinations, laboratory procedures, and hospital services as may be deemed necessary or advisable by my care provider(s).
- I understand that care provider(s) may not be employed by or agents of Facility but has/have the right to practice medicine at Facility. I may be billed separately for services provided by these providers.
- I understand that my healthcare team may be comprised of physicians, physician assistants, fellows, nurse practitioners, nurses, technicians, residents, students, other employees, and agents.
- I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees are made as to the results of my treatment or procedures performed.
- I understand that during my treatment photographing, videotaping, audio recording, and/or televising ("Recordings") may occur for care/treatment or identification purposes and will become part of my medical record.
- I understand that Recordings may be taken for education, training, educational/research publication, or quality assurance purposes. These recordings will not reveal my identity and will not become part of my medical record.
- I understand that I have the right to refuse any medications, treatment, procedures, or Recordings to the extent permitted by law.

TELEMEDICINE SERVICES:

- I understand that my treatment may include participation in a Telemedicine service/consultation. If this occurs:
  - My health care provider and I may communicate by interactive video conferencing with Pennsylvania licensed physicians and health care professionals at another location.
  - Digital images of my medical condition may be made and sent to Pennsylvania licensed physicians and other health care professionals at other locations for evaluation and consultation with my health care professional.
  - Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
  - The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained in the use of telemedicine which identifies me will be disclosed except as authorized by law.
  - I have the right to withhold or withdraw my consent to the use of telemedicine in my care at any time. This will not affect my right to future care. I understand that if telemedicine is not used, I may not have access to specialists who are not available in the community.

PROHIBITION OF WEAPONS/HAZARDS/DRUGS:

- I understand that for my health and protection, as well as the protection of others, I am not permitted to bring or have any weapons, illegal substances or drugs, hazardous materials, alcoholic beverages, smoking materials or unauthorized electrical appliances in my room, on my person, or in my belongings. I understand that the Facility may search my room and belongings, as well as confiscate and dispose of any of these prohibited items, including providing them to law enforcement.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:

- I understand that Facility has a system–wide, integrated electronic medical record that is available to caregivers on a "need to know" basis to share information about my medical care provided in the hospital, outpatient, or physician office setting.
- I understand confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS, or drug or alcohol treatment is maintained per relevant governmental and regulatory standards.
- I understand that summaries of my medical care will automatically be sent to my physicians, referring physicians, and other physicians involved in my care.

HEALTH INFORMATION EXCHANGES (HIEs) PARTICIPATION:

- I agree to participate in "Health Information Exchanges (HIEs)," which allow my healthcare providers to access my protected health information from other participating providers from whom I have received care.
- I understand that I have the option to "opt out" from sharing my protected health information with the HIEs.
- I understand if I choose to "opt out" that my choice will not affect my ability to receive medical care.

AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION:
- I understand that I may choose to be listed in Facility's public information directory. This means that my room number, telephone number and general condition can be released as a matter of public record.
- I understand that if I elect not to be listed in the Facility's public information directory, my presence in the Facility will not be acknowledged to the general public, and that I will not receive mail, telephone calls, visitors, or gifts.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:
- I understand that Facility does not accept responsibility for loss or damage to any monies, valuables, and/or personal property brought Facility.
- As an inpatient of Facility, I have been advised to send all monies, valuables, and/or personal property home with a family member, or if that is not possible, to deposit them in the Facility safe.
- While a patient of Facility, I release the Facility from any responsibility due to loss or damage to monies, valuables, and/or personal property that are not deposited in the Facility safe.

PATIENT RIGHTS AND RESPONSIBILITIES:
- I understand that I have patient rights which reflect the Facility's commitment to maintaining my personal dignity while I receive healthcare services.
- I understand my responsibility to provide my healthcare team with information that is important to my care, and to cooperate in my treatment.
- I understand my responsibility to respect the rights of others in the Facility.
- I understand that if I have any concerns regarding my care, I may talk with my doctor, nurse or any member of my healthcare team. I may also contact the Patient Advocate/Patient Representative Office.

PHOTOGRAPHY/RECORDING BY PATIENTS AND VISITORS:
- I understand that any type of Recording is strictly prohibited without the verbal consent of a healthcare provider or staff member.
- I understand that Recording must not interfere with patient care.
- I understand that individuals Recording without consent or whose Recording is deemed to interfere with patient care may be asked to stop the Recording and could be asked to leave the premises.
- I understand it is my responsibility to ensure my family and visitors comply with these requirements.

LAY CAREGIVER DESIGNATION (Inpatient Only):
- I will have the opportunity to provide the name of a lay caregiver.
- I understand that a lay caregiver is a person who agrees to assist me with my care at my residence after I am discharged from the hospital.
- I agree that my medical information may be released to my lay caregiver.

MEDICAL ASSISTANCE VERIFICATION:
- If I am a recipient of Medical Assistance, I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material information may be prosecuted under applicable Federal and State laws.

ACKNOWLDGEMENT FORM:
- I have read this form (or have had it read to me) in its entirety, have had any questions answered to my satisfaction, consent to each of the above provisions, and am signing this form knowingly and voluntarily.

_____	_____	_____
Signature of Patient OR Authorized Individual	Date	Time
_____	_____	
Printed Name of Patient OR Authorized Individual	Relationship to Patient	