Androscoggin Valley Hospital
North Country Home Health & Hospice Agency
Upper Connecticut Valley Hospital
Weeks Medical Center

NCH north country healthcare

# Consent (Authorization and Notice)

CONSENT TO TREATMENT: I voluntarily consent to any and all emergency and/or routine healthcare treatment and/or diagnostic procedures by authorized employees and agents of North Country Healthcare and its hospital affiliates, Androscoggin Valley Hospital, Upper Connecticut Valley Hospital, Weeks Medical Center, and their related clinics and delivery sites (NCH). I understand this care may include tests, examinations, procedures, biopsies, the administration of medications, blood products and anesthetics, and other treatments/procedures as believed by the provider to be necessary or advisable, and I consent to all such care. If my providers deem it necessary to utilize photography for precise documentation of a diagnosis, monitoring of treatment plan effectiveness, or for medical legal purposes, I consent to such photography and understand that they will become part of my confidential medical record. For major procedures, I will be asked to sign a separate consent form. I authorize NCH to dispose of any tissues or foreign body(ies) removed from my body during this care. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the emergent care I have authorized NCH to render. I understand that I may stop my request for treatment before any procedure or test, or before medication is given to me. I understand that my need for prompt medical attention may prevent me from giving a more specific or detailed authorization to NCH for providing me with the care that I need.

INDEPENDENT STATUS OF PRACTITIONERS: I understand that many of the providers and other members of the Medical and Allied Health Professional Staff are not employed by NCH. NCH has given these practitioners permission to use the facility for the care and treatment of their patients. If I have questions about the relationship between a care provider and the Hospital, I have the right to ask about this and receive a clear answer. I understand that the Hospital does not control or have the right to control the medical decisions and actions of practitioners, including Hospital-based practitioners who are not employees of the Hospital, and that non-employed practitioners are responsible and liable for their own action or omissions. I understand and agree that each of the practitioners who render professional services to me may bill and collect independently for these services. I understand that their bills will be separate from the NCH's billing and collections or that NCH may bill on the healthcare practitioner's behalf.

CERTIFICATION OF MEDICARE AND MEDICAID PATIENTS: I certify that the information given by me for payment under Medicare (Title XVIII of the Social Security Act) and/or Medicaid (Title XIX of the Social Security Act) is correct. I give my permission to the Social Security Administration to give the Hospital information about my Medicare benefits. The Hospital has my permission to give the Centers for Medicare & Medicaid Services information about my care in order to receive payment from Medicare/Medicaid.

PHYSICIAN ON SITE: I understand that NCH Hospital locations may not have a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) present in its facility 24 hours per day, seven days per week, and that my care may be provided by an appropriately trained Nurse Practitioner or Physician's Assistant. I understand that a medical doctor or doctor of osteopathy with training and experience in emergency care is immediately available by telephone or tele-medicine.

TELE-MEDICINE: I further agree and give my consent to participate in tele-medicine health services, including psychiatry services by tele-psychiatry, if recommended for my care and treatment. During the tele-medicine health service, details of my health information including medical history, examinations, and diagnostic tests, will be discussed with health professionals through the use of interactive video, audio and telecommunications technology. I understand there are limitations to the technology and the process of tele-medicine, including the potential for incomplete exchange, interruption or technical difficulties. I understand that the medical records of my telemedicine health services provided by telemedicine health services providers will be maintained by NCH. If I need copies of these records, I should follow NCH's "Notice of Privacy Practices" to request copies of the records from NCH.

PRESENCE OF OBSERVER: I understand that students from local schools and select community members who participate in NCH's Experimental Learning Program (the "Program") may be present to observe the delivery of care by authorized employees and agents of NCH. The Program is designed to teach individuals about healthcare and healthcare career opportunities. Individuals selected to participate in the Program meet all the Program requirements. I understand that I have the right to refuse a participant of the Program from observing me, and that my decision to permit or refuse a participant of the Program from observing me will not affect my care in any way at NCH.

PERSONAL BELONGINGS: I understand that while I am a patient at NCH, I am totally responsible for any belongings or personal property that are brought into NCH, or retained by me in NCH, or are left at NCH. I release NCH of any and all obligations regarding my belongings or personal property.

VISITORS/TELEPHONE CALLS: Unless I request otherwise, NCH will provide my room location to visitors and forward telephone callers asking to speak to me.

RELEASE OF RESPONSIBILITY FOR PARKED VEHICLES: I absolve NCH, its agents and servants, from any and all responsibility for damage to, or theft of my vehicle as a result of being parked on hospital grounds.

-CONSENTS

AFFIX PATIENT LABEL

RELEASE OF PATIENT INFORMATION: I consent to the release of information about my care to Medicare, Medicaid, or to their intermediaries, to insurers and other payors, to managed care or other utilization review groups, to any other health care providers, if needed in my treatment, or to continue my treatment after discharge from NCH, at the direction of my physician, and to any state and/or federal agencies as required by law.

TELEPHONE/EMAIL COMMUNICATION: I authorize and give express written consent to the Hospital, Physicians, Care Providers and their agents, business associates, affiliates and assignees to contact me, for any purpose related to my care including but not limited to collect my accounts, to remind me about my prescription re-fills and appointments, to notify me about products and services, and for quality assurance purposes: 1) by telephone at the number provided by me now or in the future, including wireless telephone numbers or devices and to use pre-recorded/artificial voice messages, text messages/SMS and/or an automatic dialing device (ATDS) regardless if I incur charges as a result: (2) via answering machine, voicemail message, text message or email. I understand that my consent is not required as a condition of my purchase of any property, goods, or services.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: I understand that I am financially responsible to NCH for all charges in the event I have no insurance or my insurance claim is rejected. If I have health care insurance or am entitled to Workers Compensation benefits, I agree that NCH may bill those insurers and they may make their payments directly to NCH. If my account is placed in the hands of any agent or attorney for collection, I agree to pay the expenses of collection, including reasonable attorney's fees, and the original amount of the account. I agree that any credit balance resulting from payment of insurance companies or other sources may be applied on any other account owed to NCH by me or my spouse or dependents. I agree to these terms voluntarily and of my own free will, and am under no duress to do so.

I have had the opportunity to review the Rights and Responsibilities of Patients, Notice of Privacy Practice and Nondiscrimination Statement and have been given copies if requested.

This authorization for treatment and assignment of benefits will expire one year from the date below.

I agree to all of the conditions for admission and/or treatment described above. I have had the opportunity to ask questions and have them answered to my satisfaction. I have crossed out any words or phrases I do not accept.

______________________________ ______________ ________am / pm ____________________________
Patient/Authorized Agent Signature Date Time Witness

____________________________________ ______________________________________
Print Name Relation to Patient

PATIENT IS UNABLE TO SIGN CONSENT

The patient is unable to consent due to: ______________________________________________

Verbal consent to above obtained from: ______________________________________________

____________________ ________am / pm ________________________________________
Date Time 1st Witness

______________________________________________
2nd Witness (Clinical When Indicated)

Interpreter Name: _______________________________________________ ID#: _____________________________

In cases where the patient is unable to provide consent and there is no authorized agent to provide consent, one witness signature must be from a provider or registred nurse.

–CONSENTS

AFFIX PATIENT LABEL