WESTERN WISCONSIN HEALTH

Assignment of Benefits Consent

1. **Consent to Treatment:** I recognize that I may have a healthcare condition requiring medical care, diagnosis, and treatment and voluntary consent to medical care and treatment as ordered by my healthcare provider. This consent includes hospital services, diagnostic procedures, and all medical treatment rendered under the instructions of my healthcare provider, including x-ray and laboratory procedures and other tests, treatments, or medication monitoring, and all other procedures that do not require my specific informed consent. I recognize that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatments or examinations administered. I understand I may be released from the medical center before all of my medical problems are known or treated, and that it is my responsibility to make arrangements for follow-up care.

2. **Responsibility to Refuse Treatment:** Each patient has the right to consent to or refuse any proposed procedure or therapeutic treatment. I understand I should speak to my healthcare provider if there is anything I do not want done. The healthcare provider will explain the nature of my condition and treatment and the other ways that this condition could be treated, if any. He/she will explain significant risks involved with the treatment, if any.

3. **Healthcare Education:** I understand and agree that the hospital maintains affiliation agreements with academic institutions and at times, healthcare services may be observed and/or delivered by students under the supervision and responsibility of the attending healthcare provider or other authorized medical center personnel.

4. **Right to Review and Copy Medical Records:** I understand that I have a right, upon written request and with reasonable notice, to inspect and receive a copy, at my expense, of my medical record and x-ray reports/films. I understand that this review shall take place in the Health Information Management Department during regular business hours (Monday through Friday 8:00 a.m. to 4:30 p.m.)

   I also understand that I may authorize other persons to review and copy my medical record by signing Western Wisconsin Health's required authorization, which identifies the person, the purpose of the disclosure, the type of information to be disclosed, and the time period during which disclosure to the person is permitted. I understand that I may revoke this authorization at any time, except to the extent that the medical center, its employees and/or agents, may have already acted in reliance on it, and that, except for such revocation, it will remain in full force and effect for 90 days from the date of my signature.

5. **Consent to Photograph:** I understand that photographs, videotapes, digital or other images of me may be recorded for the purpose of treatment and/or documentation in my record. I hereby consent to the use of these images for this stated purpose only. I also understand that if Western Wisconsin Health or others request to photograph or take images of me for any purpose, a written consent to do this must be obtained from me prior to being done.

6. **Personal Valuables:** Patients are discouraged from bringing valuables to the medical center. Western Wisconsin Health will not be responsible for valuables not deposited in safekeeping.

Please Place a Current Admission Sticker Here When Available

Patient Name: _____

Date of Birth: _____ Med Rec #: _____

7. **Financial Agreement/Assignment of Benefits:** I request that payment of authorized benefits for this treatment be made on my behalf to, and herby assign benefits directly to Western Wisconsin Health. I hereby assign the benefits payable for the provider services to the provider/organization furnishing this service or authorize such provider/organization to submit a claim to Medicare for payment to me. I authorize Western Wisconsin Health or its agent, to release any and all information from my medical records relating to this admission to any and all insurance, third-party carriers, other treating facilities, or any person whom the medical center reasonably believes to be responsible for the payment of my bill. I understand that I am financially responsible for all charges associated with this admission including, but not limited to, those charges not covered by third-party payers. I understand that Western Wisconsin Health will not accept responsibility for collecting insurance or negotiating a settlement of a disputed claim. All charges are payable in full 30 days from date of discharge/service or third-party payment. In the event that legal action is necessary to collect this account, I agree to pay reasonable attorney fees and collection expenses.

8. **Facility Directory:** I understand that if I am admitted to the medical center I have the option to be included or excluded from the Facility Directory. If I choose to be excluded I understand that mail addressed to me will be returned and flowers will not be delivered to me. My presence can neither be confirmed nor denied to individuals inquiring about me. If I am unable to communicate my preferences, I understand that a past preference of mine will be used until such time that I can express my preference for inclusion or exclusion from this directory.

9. **Information Privacy:** I understand that Western Wisconsin Health will use and disclose my personal health information for treatment, to receive payment for the care I receive, and for other healthcare operations. The information to be released may include psychiatric, developmental disability, alcohol or drug abuse information, AIDS/HIV testing, and AIDS/HIV related disease diagnosis. I understand that a Notice of Privacy Practices document that provides a more complete description of information uses and disclosures is available for me to receive. The terms of this privacy notice may change with time and the medical center will post the current notice at its facilities, on its website and have copies available for distribution. I understand that I can discuss my concerns and questions about the privacy of my protected health information with Western Wisconsin Health's Privacy Officer.

10. I acknowledge that I have received a copy of the Western Wisconsin Health's Notice of Privacy Practices.

11. I have received the Important Message from Medicare and/or Champus, if appropriate.

12. I have read the above and understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

_____ **Date/Time:** _____

Patient Signature

Patient is a minor or is unable to consent because: _____

_____ / _____

Signature of Parent / Legal Guardian / Authorized Representative **Relationship to Patient**

_____ **Date/Time:** _____

Witness

Please Place a Current Admission Sticker Here When Available

Patient Name: _____

Date of Birth: _____ Med Rec #: _____