WESTCHESTER MEDICAL CENTER
WORLD-CLASS MEDICINE THAT'S NOT A WORLD AWAY.®
VALHALLA • NEW YORK • 10595

General Consent for Routine Treatment

IF NO LABEL, PRINT PATIENT'S NAME, MR NO., GENDER, ROOM

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of Westchester Medical Center (WMC), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at WMC.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct WMC and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND CHARITY CARE NOTICE: I hereby authorize and direct my insurance carrier and/or health care plan to make payment to WMC and hereby assign to WMC any and all rights, title and interest I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by WMC. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to WMC for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. I understand I will receive a separate bill from my attending physician, emergency department physician, radiologist, anesthesiologist and other consultants. (However, if treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules.) As part of WMC's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. WMC has a Charity Care Program for patients who financially qualify. Please ask for more details.

IF ADMITTED AS AN INPATIENT: I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare", information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient) with information about how I can exercise the right explained in these materials. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed.

_____ Initials RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the hospital and understand and agree that WMC shall not be liable for loss or damage to any personal property.

HIV TESTING: I have been given information regarding HIV testing, how HIV can be transmitted, that there is treatment for HIV/AIDS, how to keep myself and others safe from HIV infection, that testing is voluntary and can be done through confidential testing, how my HIV-related information will be kept confidential, and what laws protect people with HIV/AIDS from discrimination. I understand that the results will be documented in my medical chart.

Consent for HIV-related testing remains in effect until I revoke it or until the following date _____. I may revoke my consent orally or in writing at any time. As long as this consent is in force, Westchester Medical Center may conduct additional tests on me without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will make a note in my medical record.

Print Patient Name: _____ Date: _____

_____ I do not want an HIV test

Signature: _____
(Patient or person authorized to consent)

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____
(Patient)

Signed _____
(Legal Authorized Representative)

Witness _____

Date _____

TELEPHONE CONSENT IS GRANTED BY (if required)

_____
(Name of legal authorized representative and relationship to patient)

_____
(Signature of Caller)

Witness _____

Date _____

MEDICARE PATIENTS ONLY - LIFETIME RESERVE DAYS: In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days.

Signature: _____