

## CONSENT TO MEDICAL CARE AND TREATMENT

- 1. CONSENT.** I voluntarily consent and authorize Memorial Hospital and Memorial Care Center ("Memorial") to render healthcare services, including routine hospital services, such as diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, including the use of restraints, which my attending physician or other holders of clinical privileges consider medically necessary. I understand that healthcare services may be rendered by students, interns and residents under supervision. I further understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee or assurance has been given to me regarding treatment or services rendered in this healthcare facility.
- 2. INDEPENDENT PRACTITIONERS - [IMPORTANT].** In seeking treatment at Memorial, I understand and agree that:
- a) Memorial does NOT employ physicians, dentists, podiatrists or other allied health professionals and that they are **NOT agents or employees of Memorial**. Memorial cannot and does not control the practice of medicine by these independent medical practitioners. Memorial is NOT legally responsible for their treatment decisions, professional judgments or actions involved in my care.
  - b) Non-employed independent practitioners include physicians, physician assistants, nurse anesthetists, and mid-wives providing certain professional services at Memorial, such as emergency medicine, anesthesiology, radiology, pathology and the interpretation of various diagnostic tests. I understand I may receive services from Belleville Emergency Physicians, P.C., Cardinal Glennon Care a/k/a Glennon Care, Anesthesia Associates of Belleville, Ltd., Advanced Diagnostic Imaging, Ltd., and from St. Louis University and other independent practitioner/entities. **I acknowledge that NONE of these professionals and allied health professionals are employees or agents of Memorial.**
  - c) If I do not have a personal physician on Memorial's Medical Staff, I will be referred to an independent physician who is neither an employee nor agent of Memorial. If I desire a different physician, it is my responsibility to arrange for another physician with staff privileges to care for me.
  - d) I will receive a separate bill from independent medical practitioners affiliated with Memorial. I understand that I may have greater financial responsibility for services provided by healthcare professionals at Memorial who are not under contract with my healthcare plan. I agree to direct questions about my coverage or benefit levels to my plan.
- 3. PREGNANCY STATUS.** I understand that if I am pregnant or think I may be pregnant, I **MUST** inform each of my care providers and my physicians **BEFORE** any testing, care or treatment is received by me.
- 4. AUTHORIZATION TO RELEASE AND DISCLOSE MY MEDICAL CARE INFORMATION.** I authorize Memorial to release medical and financial information, my social security number and medical records to the following persons or groups: (a) any physician or healthcare provider supplying services to me; (b) any third party which is or may be liable to Memorial or my physicians for all or part of their charges including, but not limited to, Hospital or medical service companies, insurance companies, Workers' Compensation carriers, or my self-insured employer; (c) any person or entity for scientific, education, research or statistical purposes; (d) any person or entity for peer review, quality assurance, discharge planning, utilization review, risk management or appeal organization. This release and authorization extends to interviews and discussions relative to the content of such medical records by my physicians or Memorial's personnel regarding the services provided.

Do not write below this line



5. **RELEASE REGARDING PERSONAL VALUABLES.** I understand that Memorial discourages bringing personal valuables to the facility and that safekeeping arrangements for my valuables may be provided upon request. I release Memorial from responsibility for loss of or damage to my clothing, watch, jewelry, dentures, radios, music devices, personal data assistants, cell phone, computer, cane or other valuables.
6. **FINANCIAL AGREEMENT.** I agree to pay Memorial any and all charges for hospital care or medical treatment or services furnished to me or on my behalf. I understand that there is no guarantee of reimbursement or payment from any insurance company or other third party payor. All charges are due and payable upon receipt of the bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt incurred as a result of services provided to me. **If I do not have sufficient resources to pay for my hospital charges, I understand Memorial offers assistance to financially eligible patients. To qualify, I must have already applied for available government assistance programs, meet specific income guidelines, have completed Memorial's Application for Financial Assistance and have supplied all required financial information to Memorial.** I consent to the receipt of auto-dialed, artificial or prerecorded messages to my cellular telephone and /or to any telephone number provided by me or my agent to Memorial, its affiliates, agents and assigns, including without limitation any account management companies including debt collectors.
7. **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for healthcare services or goods be made directly to Memorial. I understand I am financially responsible for charges not covered or paid pursuant to this authorization.
8. **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to obtain all preauthorizations and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the Hospital's charges.
9. **CERTIFICATION & ACKNOWLEDGEMENT.** I certify that the information given by me in applying for payment under Medicare, Medicaid or other insurance programs is correct. I further certify that I am the patient or a representative of the patient duly authorized to act on his/her behalf. I have read this Consent in its entirety and any questions I had were answered or explained to my satisfaction. **I agree to all of the above and I specifically acknowledge that any physicians or other Allied Health Professionals who treat me at Memorial are independent practitioners and that they are not agents or employees of Memorial. Knowing this condition, I still request treatment at Memorial.**
10. **By signing below, I hereby acknowledge receipt of Memorial's "Federally Required - Notice of Privacy Practices."**

Patient unable/unwilling to sign. Delivery of privacy notice attempted.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Other Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

-----  
Do not write below this line

