GENERAL CONSENT TO HOSPITAL CARE

The undersigned patient or patient's authorized legal representative hereby consents to admission to Mercy Medical Center for diagnostic tests, procedures, care and treatment. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made as to the result of the testing procedures, care or treatment in the hospital. I consent to and authorize the following:

CLINIC

Medical Consent: I consent to hospitalization, diagnostic tests (including X-ray and laboratory), and other hospital procedures and therapy performed or prescribed by the attending physician, his designees or assistants, during this hospitalization. I consent to photographing and videotaping of operations or procedures, attendance of observers, disposal of any tissue or parts removed, all or any of which is deemed advisable by the doctor or assistant.

Blood Transfusion: I consent to the transfusion of blood and blood products as deemed necessary. (If refused, sign Refusal to Permit Blood Transfusion).

Advance Directive: I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. The hospital will provide me with information about Advance Directives.

RELEASE

Release of Confidential Information: I authorize Mercy Medical Center to release any information, including information from my medical record necessary to facilitate health care claims processing and payments. I understand that a separate authorization may be required for the release of my medical records containing specific information related to the testing, diagnosis and/or treatment of sexually transmitted diseases (including HIV), alcohol or drug abuse, and mental health/psychiatric disorders. I also consent to the release of any information as needed for post-discharge care or transfer of care to other health care facilities or agencies as I direct or as required by law. (If refused, please draw a line through and initial.)

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

Patient Portal: Mercy provides online access to your health information, including test results through a Patient Portal.

Patient Rights and Responsibilities: Your rights and responsibilities are respected at Mercy. Each department and every patient room has a copy of your rights and responsibilities for your reference.

FINANCIAL

Preauthorization: Many insurance carriers require preauthorization and/or second opinions. I understand that meeting these requirements is my responsibility.

Assignments of Benefits: In the event I am entitled to hospital benefits of any type whatsoever arising out of any insurance policy insuring me or any party liable to me, said benefits are hereby assigned directly to the hospital for application on my account. I understand I am financially responsible to the hospital for any charges not paid under this assignment and agree to pay such charges in accordance with the financial agreement signed by me on my behalf.

Financial Agreement: I agree to pay for any services rendered in connection with my stay at Mercy Medical Center. The balance of my bill is due 30 days from the first date of billing. If I am unable to pay, a payment plan may be established. If payment of the bill creates a financial hardship, I understand I may inquire about assistance by contacting a Mercy financial representative. The hospital reserves the right to require payment of insurance co-pays, deductibles and deposits in advance of hospitalization or at the time services are rendered. I understand I am responsible for any charges not covered by my insurance.

You will receive a separate bill for consulting physicians and other health care professionals who provide services to you as ordered by your doctor. The Radiology, Pathology and Anesthesiology charges on your statement are for materials and facilities. I acknowledge that the health care providers treating me may be independent contractors not employed by the hospital. I specifically acknowledge that any radiologists, anesthesiologists, pathologists and emergency room physicians involved in my care are independent contractors and not employees of the hospital.

NOTE

Personal Valuables: I acknowledge that the hospital maintains a safe for the safekeeping of money and valuables and shall not be liable for the loss or damage of any money, jewelry, documents or other small articles of value unless deposited for safekeeping. I understand that I am responsible for all valuables and personal belongings retained and taken to my room.

YOUR OPINION MATTERS TO US

Mercy's priority is to ensure that you are provided safe, high-quality care and exceptional services. It is important that we receive feedback from our patients about how well we met their expectations in relation to their hospital stay or procedure. Please feel free to share your comments with any staff member who is providing care to you. We want our patients to know that we also use the services of a company(s) to assist us in gathering information through a survey. If you are randomly selected to participate, you will be contacted by the survey company. We will use the feedback we receive for quality assurance purposes and to improve our performance and service.

I acknowledge that this form has been fully explained to me and that I have read and understand its contents and the attached Notice of Patient's Rights. I also acknowledge receipt of a copy of these forms. I certify that as the patient, his/her representative or legal guardian, I accept the terms of this document.

Patient or Patient's Representative

Relationship

Do not sign at this time.
You will sign on the day of your surgery.

Witness

Date and Time

PACK 8600109 (2/15)

ORegon SURGERY CENTER
A division of Mercy Medical Center
2801 N.W. Mercy Drive, Suite 200 • Roseburg, OR 97471

PATIENT LABEL

DT0048