Print Form

WOOSTER COMMUNITY HOSPITAL

GENERAL CONSENT FOR TREATMENT

I understand that medically necessary treatment, tests (such as blood tests, laboratory tests, x-rays, etc.) and procedures may be performed on me as an inpatient, outpatient, or patient in the Emergency Department of WOOSTER COMMUNITY HOSPITAL. Medical services may be performed by my personal doctors or by Emergency Department doctors. I understand that doctors, including the Emergency Department doctors, are not employees of WOOSTER COMMUNITY HOSPITAL. No one guaranteed the results of any treatment, test or procedure. I understand I may need to sign a separate informed consent for surgery and certain invasive procedures.

If I am admitted as a patient to WOOSTER COMMUNITY HOSPITAL, I may be seen by my personal doctor. If I do not have a personal doctor, a doctor may be assigned to attend to me. If I am treated and discharged from the Emergency Department, I will be instructed to use my personal doctor in follow-up. If I do not have a personal doctor, I may make a follow-up visit with the on-call doctor assigned. I understand that being seen in follow-up by assigned on-call physician does not create an obligation for that doctor to accept me as a regular patient. That will be a mutual decision between the doctor and I.

AGREEMENT TO PAY AND ASSIGNMENT OF BENEFITS

By signing below, I agree to pay (or agree to accept financial responsibility for and guarantee payment to) WOOSTER COMMUNITY HOSPITAL for hospital services rendered, including treatment, tests and procedures for which I have consented. To the extent I am entitled to receive medical insurance or benefits through one or more payers, I agree by my signature to assign to WOOSTER COMMUNITY HOSPITAL payment of all insurance and medical benefit coverage due by each payer. I understand that under Ohio law, I may request a list of usual and customary charges and rates.

CONSENT TO ASSIGN AND PERMIT PAYMENT OF MEDICAL BENEFITS UNDER THE SOCIAL SECURITY ACT (MEDICARE) TO HOSPITAL AND PHYSICIANS

I certify that the information I gave in connection with applying for payment under Tide XVIII of the Social Security Act is complete, true and accurate. I consent for WOOSTER COMMUNITY HOSPITAL and doctors who treated me, who are holders 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 related Medicare claim. I authorize WOOSTER COMMUNITY HOSPITAL and doctors who treated me to submit claims on my behalf. I request and consent that permitted reimbursement and payment of authorized benefits be assigned to WOOSTER COMMUNITY HOSPITAL and to the doctors who treated me.

ACKNOWLEDGMENT OF RECEIPT OF MEDICARE CO-INSURANCE NOTICE

WOOSTER COMMUNITY HOSPITAL is notifying me that, if I am a Medicare beneficiary, I will be responsible for paying the Medicare deductible and the amount of co-insurance for health care and medical services I receive as an outpatient at WOOSTER COMMUNITY HOSPITAL and at HEALTHPOINT. Co-insurance means that percentage of the bill that I must pay. Typical co-insurance amounts can range from 20% to 50% of the Medicare payment rate. It is likely that the amount of co-insurance I am required to pay will fall within this range. This is only an estimate. Medicare determines the actual amount I must pay. My signature below acknowledges my receipt of this Notice before I receive health care and medical services for which I will be responsible for paying co-insurance.

_____	_____	_____
Witness	Beneficiary or Beneficiary's Authorized Representative	Date

REQUEST FOR PRIVATE ROOM

I, _____, request a private room. I agree to pay to the hospital the difference between the established rates of the hospital for the accommodations specified in my contract, and the more expensive accommodations requested, which is $_____ /day.

PROPERTY STATEMENT

I understand and agree that I am solely responsible for any personal property I bring in to WOOSTER COMMUNITY HOSPITAL. I have been informed that the Hospital has a safe into which I may store my personal property while I am a patient. I expressly waive any claim against WOOSTER COMMUNITY HOSPITAL for ANY loss of, or damage to, personal property that I do not deposit in the safe, but instead, voluntarily keep in my possession.

Valuables placed in the Safe? ☐ Yes ☐ No Valuables Envelope No. _____

SIGNATURE

By signing below, I understand, acknowledge and agree that: (1) I have read this form or had it read to me; (2) 1 understand it and the consequences of signing it (3) that I have had an opportunity to ask questions, and my questions were satisfactorily answered; (4) 1 am properly acting on my own behalf or as the authorized legal representative for the patient; and (5) that I am knowingly and freely signing, unconditionally and without reservation, and am accepting financial responsibility.

_____	_____	_____
Witness	Patient or Patients Authorized Representative	Date
	_____	_____
	Insured (if other than patient)	Relationship

39489 CR026 REV. 07/07

REGISTRATION CONSENT FORM