Authorization and Release

FORM PATIENT ACCESS MANAGEMENT

Patient Name: _____ MRN: _____

DOB: _____ HAR: _____

1) Authorization for Treatment: I hereby authorize and consent to the administration and performance of all treatments (during this hospitalization or on an outpatient basis including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, x-ray/radiologist examination, medical treatment, hospital services or home care rendered for the patient) by the physician in charge of the above-named patient, or other physicians of the hospital's medical staff considered to be necessary or advisable. Further, I realize that among those who attend patients in this hospital are medical, nursing, and other healthcare personnel in training who, unless requested otherwise, may be present during patient care as part of their educational process and will be supervised.

2) Consent for Emergency Treatment: I believe that I am suffering from an emergency medical condition, I know this condition entitles me to an appropriate medical screening and treatment necessary to stabilize my condition. I therefore authorize the Hospital to provide an appropriate medical screening evaluation and treatment to be performed by or under the supervision of a physician or his/her aide. It has been explained to me that the diagnostic treatment procedures, which my emergency medical condition legally entitles me, are limited and will include a medical screening examination. If may be necessary for me to select another physician and obtain from him/her a complete diagnosis of my condition and such continued treatment as he/she may prescribe.

3) HIPAA Compliance: JRMC will release health information only in accordance with HIPAA and applicable privacy laws.

4) Medicare - Patient's Certification, Authorization to Release Information and Payment:
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 and/or the Medicare Program or intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

5) Assignment of Benefits: This assignment of benefits allows the Hospital and/or hospital-based physician to be paid directly to my health insurance carrier or other health benefit plan for the services the Hospital and/or hospital-based physician provide to me, my minor child, or other person entitled to healthcare benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the Hospital and/or hospital-based physicians all rights, title and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Hospital and/or hospital base physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Hospital and/or hospital-based physicians to pursue any such right of recovery- I have read and been given the opportunity to ask questions about this agreement of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Hospital and hospital-based physicians. I understand that I may receive separate bills for various physician charges, including radiology, pathology. and/or emergency room service.

6) Financial Agreement: If I am the patient, or an individual legally obligated to pay for medical services for the patient, I hereby agree to pay Jamestown Regional Medical Center and any physician participating in the treatment and care for any and all services rendered to the patient. I understand any contract or agreement between the patient and a third party to transfer financial responsibility does not involve Jamestown Regional Medical Center or change my obligation to pay. I hereby acknowledge financial responsibility for any and services rendered which the insurance plan may exclude from payment, either

because the plan deems such services not medically necessary, or for any other reason, including pre-certification requirements, second opinions, or pre-existing conditions. I hereby acknowledge it is my sole responsibility to ensure Jamestown Regional Medical Center has the most up to date eligible coverage for myself and/or my dependents, otherwise I will be responsible for payment in full due to missing timely filing deadlines set forth by my insurance. I shall hereby be responsible for payment in the event the insurance plan does not pay within the Hospital payment terms.

7) Video monitoring: If admitted, I understand and consent to the use of video monitoring in my room for the purpose of fall prevention to enhance my safety and support timely staff response if I am identified as being high risk for falls. I understand the video does not include audio recording and the system is intended to supplement, not replace, routine nursing care and rounding and my privacy and dignity will be maintained to the highest standards at all times.

8) Signature:
This form is valid for 12 months or until revoked. A photocopy of this Authorization and Release form is as valid as the original.

Are you filing VA benefits today?

☐ NO

☐ YES (If YES, has referral been obtained? If YES, use special guarantor.)

Is your visit related to an injury?

☐ NO

☐ YES (If YES, detail notes to account with selection below.)

☐ MVA ☐ Other: _____ WSI/WC Claim #, if known: _____

Are you receiving Home Health or Hospice services?

☐ NO

☐ YES (If YES, contact Home Health Billing Specialist at ext. 4200.)

I hereby certify and state that I have read, and that I fully and completely understand the above Authorizations and Releases, and that I have signed these Authorizations and Releases knowingly, freely, and voluntarily. The undersigned certifies that he/she is either the patient or the patient's representative.

Signature of Authorized Representative | Relationship, if Not Patient | Date

If unable to sign, indicate reason:

☐ MINOR ☐ IMPAIRED ☐ MEDICAL CONDITION: _____

Healthcare Witness Signature | Date