LAKE HEALTH
PATIENT CONSENT FORM Page 1 of 2

Name:____________________

DOB:_____________________

REQUEST FOR GENERAL TREATMENT

I request and authorize Lake Health, its employees, my physician and other physicians or allied health professionals as are necessary to provide emergency, outpatient and/or general hospital treatment and care. Further, I authorize the hospital and my physician(s) to permit the presence of observers in my treatment as deemed necessary.

I, ____, understand and acknowledge that from time to time, medical
(Patient Name)
students, nursing students or students of other healthcare disciplines may be undergoing clinical education in various departments at the hospital. I hereby authorize and permit such students of any such health profession to participate in my care insofar as they are properly supervised at all times by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

I also understand that some physicians and healthcare providers, including, but not limited to anesthesia, pathology, radiology, surgery, and emergency department providers are independent practitioners (“Independent Practitioners”) and are not employees or agents of Lake Health. They are independent contractors acting as my (patient’s) agent. Lake Health is not responsible for the acts or omissions of such Independent Practitioners.

Patient Best Contact Number: ______________________________ X (Signature) ______________________________________

NOTICE OF INCREASED EXPOSURE TO COVID-19

I understand that during the ongoing COVID-19 pandemic, traveling to Lake Health facilities will increase my possible exposure to COVID-19. I will follow all standard safety precautions required by Lake Health and the State of Ohio when traveling to Lake Health for any treatment. I authorize Lake Health to follow standard precautions to protect myself, Lake Health staff, and other patients including taking my temperature upon arrival and asking me questions to assess my health. If I am experiencing any of the following symptoms I may be asked to reschedule my appointment: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose, or sore throat.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Lake Health, Anesthesia Associates, Community Hospitalists, Inc., Drs. Hill & Thomas, Drs. Hill & Chapnick, EKG Associates, US Acute Care Solutions, and other interpreting physicians involved in my care to release any medical records or medical information necessary to file an insurance claim, to perform quality and utilization assessments, and to release any medical information which may be requested by my insurance carrier or agencies on their behalf. I authorize the release to other health organizations and/or professionals such medical information deemed necessary to ensure continuity and quality of care to my routine health care provider (Primary Care Physician) or in the event of my transfer to another institution. Further, I authorize release of medical information to a quality assurance of peer review committee or organization, compliance audits, research, marketing, Department of Health, federal and/or state agencies.

ELECTRONIC COMMUNICATIONS

I understand that Lake Health may utilize, or make available to the healthcare professionals involved in my care, various technologies that are secure, confidential, and meet federal and state privacy and security requirements to allow providers involved in my care to communicate with each other and facilitate clinical decision-making regarding my care. Examples include, but are not limited to: secured texting, taking and sending photographs via secure technology, and other electronic communications.

ASSIGNMENT OF BENEFITS

In consideration of medical services to be received for this admission, I assign to Lake Health or any Hospital-Based Physician, as applicable, all, including Title XVIII of Social Security Administration, other benefits herein specified. This assignment shall be irrevocable.

GUARANTEE OF ACCOUNT

I guarantee payment of any and all hospital or Independent Practitioner charges not covered by insurance of this assignment, including court costs, if appropriate.

AUTHORIZATION TO BE INCLUDED IN DIRECTORY

Lake Health maintains a directory of individuals in its facility that includes the individual’s: 1) name; 2) location at Lake Health’s facility; 3) condition, which is described in general terms and does not communicate any specific medical information about the individual; and 4) religious affiliation. This information may be provided to members of the clergy or, except for religious affiliation, to any person who asks for the me by name. I wish to have my information listed in the directory. ☐ Yes ☐ No

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Name:_________________

DOB:_________________

AUTHORIZATION TO BE CONTACTED FOR FUND RAISING

From time to time, Lake Health may use certain information (e.g., patient ID, name, address, telephone number, dates of service, age, and gender) to contact you to raise funds for the benefit of Lake Health's charitable mission. I wish to receive fundraising communications in the future. ☐ Yes (I understand that I may opt-out of fundraising communications at any time.) ☐ No

YOUR CONSENT FOR CALLS AND / OR TEXT MESSAGES TO YOUR CELLULAR PHONE

I expressly consent to you using my cellular phone number for you, your affiliates or any third party acting on your behalf including collection agencies, calls or text messages, for collection purposes or other account related purposes. Further, I expressly consent to receiving phone calls made by an auto dialer and/or any automatic telephone dialing system from you, your affiliates or any third party acting on your behalf, including collection agencies, telephone calls for collection purposes or for other account related purposes to any cell phone number obtained from me, from any other source, or as a result of a receiving a cellular phone call from me. ☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF MEDICARE/CHAMPUS INFORMATION

I acknowledge that if I am a Medicare and/or CHAMPUS beneficiary, I have been provided with a notice from Medicare and/or CHAMPUS, regarding my rights as a Medicare and/or CHAMPUS hospital patient.

PATIENT RIGHTS

I acknowledge that I have received a copy of "Patients Rights and Responsibilities." ☐ Yes ☐ No

PATIENT PRIVACY

I acknowledge that I have received a copy of "The Notice of Privacy Practices." ☐ Yes ☐ No

PERSONAL CHOICES

I have an Advance Directive - Living Will ☐ Yes ☐ No
I have a Durable Power of Attorney for Health Care ☐ Yes ☐ No
I am an Organ Donor ☐ Yes ☐ No
I wish to receive information about other Lake Health programs ☐ Yes ☐ No
I wish to be included in the clergy census ☐ Yes ☐ No

OBSTETRICS

This consent covers this visit/admission and any subsequent visit/admission relating to this pregnancy.

SERIES

This consent covers this visit and any subsequent visit related to this encounter.

NON-COVERED SERVICES OR EQUIPMENT

Check Insurance Type: ☐ Medicare ☐ Kaiser ☐ Other ______________________________

I understand that the service(s) or equipment checked below are considered to be non-covered by my insurance carrier including Medicare. Because this service/equipment is non-covered, I realize that I will be personally responsible for payment.

Check appropriate service:

☐ Cardiac Rehab Phase III ☐ Durable Medical Equipment
☐ Pulmonary Rehab Phase III ☐ Mammograms (beyond limitations of coverage)

PATIENT BELONGINGS

Patients are responsible for all money and valuables during their Lake Health admission or outpatient visit. Lake Health is not responsible and accepts no liability for lost, misplaced, stolen or retained belongings including but not limited to money, jewelry, dentures, hearing aids, eye glasses, or other prosthetic devices.

I HAVE REVIEWED AND CONSENT TO ALL APPLICABLE CLAUSES BY SIGNING BELOW. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Signature X ______________________________ Relationship to Patient: ______________________________

Witness to the above signature: ______________________________ Date: ____/____/____ Time: ______________

An employee of Lake Health may witness this consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Lake Health.

Grievance Process: Should you experience dissatisfaction with your care or services while you are a patient you may call (440) 953-6265 or ext. 6265 to report your concerns. You will be contacted and followup on your concerns will occur.

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