



**FINANCIAL CONSENT
FOR EXAMINATION AND
TREATMENT**

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PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

This Consent for Examination and Treatment applies to _____ referred to a "Provider" hereinafter.

1. Consent to Medical Treatment/Services and Surgical Procedures

I hereby authorize Provider, the provider(s) treating me, and whomever they may select as their assistants, to provide reasonable and necessary medical treatment to me, including but not limited to, emergency care, administration of approved drugs, nursing care, and radiology and pathology services. I understand it is the responsibility of my physician or surgeon to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered under the general and special instructions of the physician. I understand that in many instances the physicians and surgeons furnishing services to me are independent contractors and are not employees or agents of Provider. If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any of those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R. S. 40:1299.53.

2. Specimens

I authorize and consent to the preservation, examination, testing, retention, use, including, without limitation, the use for scientific, diagnostic, therapeutic or educational purposes, or disposal, by Provider, at its discretion, of any specimens, tissues, materials, or substances which may be removed during a diagnostic procedure, therapeutic intervention or medical treatment.

3. Photography

I consent to photographs, videotapes, digital or other images that may be recorded to document my care. I understand that these images may be used for treatment, health care operations, scientific, educational, research, patient identification, or security purposes. I understand that these images will be stored in a secure manner and will only be used for reasons other than those outlined above upon my written authorization, or as otherwise permitted by law.

4. Telemedicine

I consent to having some or all of my medical services provided by video or other interactive telecommunication technology as allowed by law. I understand that I may decline to receive medical services via telemedicine or withdraw from such care at any time.

5. Education

I have been informed and understand that Provider is a teaching institution and the procedures performed may require observation, cooperation and services of multiple health care providers. I authorize and understand that my care may be provided by student nurses, technicians, therapists, interns, residents, fellows and other providers and observers, which are supervised by qualified faculty and/or personnel, in accordance with policies of the Provider. I also consent to the presence of manufacturer's representative(s) during certain procedure(s) to observe and provide technical consultation to the physician(s) at the discretion and approval of the physician(s) and Provider.

6. Drugs

Unless my provider specifies otherwise, I agree and consent to Provider dispensing chemically identical or therapeutically comparable ("generic") drugs from a drug list approved by the Provider's Medical Staff, as part of its formulary system.

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7. Devices

I consent to disposal of explanted medical device unless I specifically request it to be retained prior to procedure.

8. No Guarantees

I acknowledge that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the outcome and/or result of any Medical Treatment/Services.

9. Blood

I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including, without limitation, Hepatitis B and C as well as HIV/AIDS. I understand that I can decline HIV testing if it is for routine screening. I understand that state law requires Provider and/or physician to report certain infectious diseases including sexually transmitted diseases to the state Department of Health.

10. Waiver of Liability for Loss of Personal Property

Provider encourages patients and families NOT to store money and valuables at Provider facilities; these items should be left at home or with family members or other caregivers. Some Provider facilities have designated secure areas for the safekeeping of money and valuables (including but not limited to, money, jewelry, documents, fur garments, dentures, eyeglasses, hearing aids, prosthetics, or other personal property). Provider will not be liable for the loss of or damage to any personal property not formally deposited in a designated secure area.

11. Assignment of Benefits

I hereby assign and authorize, whether I sign as agent or as Patient, direct payment to Provider and/or to any hospital based physician of all insurance and health plan benefits, including, but not limited to, federal healthcare program benefits, otherwise payable to or on behalf of me for this hospitalization or for these outpatient services, including emergency services if rendered. It is understood by me that I am financially responsible to Provider for charges not covered by this assignment.

12. Authorization for Healthcare Related Calls, Texts, and E-mails

I authorize Provider, its employees, agents, representatives and/or designees to contact me using prerecorded/artificial voice messages and/or automatic dialing service at any telephone number (including a wireless telephone) that I disclose to Provider. This consent and authorization will apply to text messages sent to the wireless numbers I disclose to Provider as well as emails using any email address that I provide to Provider.

13. Authorization to Release Information

I hereby authorize Provider to obtain my medical information from other health care providers and suppliers as needed for my care and treatment. I authorize Provider to disclose, for review and/or copying, any of my medical information compiled during my admission as may be requested by my insurance company (private or governmental, i.e., Medicare or Medicaid), or other financially liable third party and/or their designated agent(s), for my benefit determinations, payment for services provided to me, and determination of the appropriateness of my admission or continued admission to, and length of stay at Provider location. EXCEPT AS I MAY SPECIFICALLY DIRECT OTHERWISE, I further authorize Provider to disclose my medical information to persons participating in my care. I understand that some of these providers and suppliers may be independent persons or entities that are involved in my medical care. I understand that State and Federal regulations may also require Provider to report information about me for public health or





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safety purposes including, but not limited to, reporting to immunization registries.

I further understand that Provider belongs, directly or indirectly, to the Greater New Orleans Health Information Exchange (GNOHIE). GNOHIE allows other providers to see your health records including your health history, the medicines you take, test results, surgery reports, hospital discharge notes, and other health information. The sharing of this information saves time and helps providers give you better care. If you do not want GNOHIE to share your records, you can “opt out” of GNOHIE at any time by calling toll-free 1-855-446-6443 or by visiting the website at www.gnohie.org and clicking on “FAQs.” Your records for treatment, payment, and operations will be shared until GNOHIE receives your “opt out” directive. I further understand that Provider may participate in secure information exchanges designed to promote efficient, high quality care. These exchanges allow other providers to see your health records including your health history, the medicines you take, test results, surgery reports, hospital discharge notes, and other health information. If you do not want to share your records with these exchanges, you can “opt out” of at any time by sending a completed and signed Opt-Out Form by mail to LCMC/Children’s Medical Records Department, 1033 Calhoun Street New Orleans LA 70118 or by fax to 504 896-9214. If you opt out of these exchanges, you will be excluded from all exchanges that Provider participates in.

14. Financial Agreement

I hereby obligate myself to pay Provider for all care, services, and treatment I receive, according to Provider’s regular rates and fee schedules. If I am covered by a health plan or insurance policy, I agree to provide current and accurate information prior to or at the time of admission/ registration. I certify that all information that I have provided or shared with the Provider is true and accurate and that I have complied with all insurance company requirements for referrals, pre-authorizations, and family coverage to avoid payment denial. I understand that if I have failed to comply with these requirements, I will be responsible for the bill. If I am eligible to receive benefits under a health care service plan with which Provider has contracted, I may be required to pay for some services pursuant to the plan’s contract. If I prefer a private room during an inpatient stay, I understand that I may be responsible for its cost. If my health care plan determines Provider’s services to me are not medically necessary, I authorize Provider to represent me in any review of the determination made by or on behalf of my health care plan. If non-insurance payments made on my account exceed the total amount due, including without limitation to any late charge, Provider is authorized to apply that excess to any pre-existing account for prior medical services furnished. In the event, my account becomes delinquent and is referred to an attorney or a collection agency, I will be expected to pay attorney fees, court costs, and collection expenses. I understand that I am responsible for any non-covered services, deductibles, and co-payments. All delinquent accounts shall bear interest at the maximum rate allowed by law. ***I understand that I will receive bills both from Provider and any independent physicians or other practitioners involved in my care.***

I understand that this General Consent for Examination and Treatment will remain in effect and apply to all treatment or services I receive unless I revoke it, in writing, except to the extent that Provider has already taken action in reliance therein. I also understand that I may be asked to provide informed consent for specific procedures, treatments, or services rendered by Provider, a physician, or other healthcare providers affiliated with Provider and that such informed consent will include, but is not limited to, the benefits and risks associated with a specific procedure, treatment, or service. Such informed consent will be presented to me in a separate document or electronic medium and will be made part of my medical record.

FINANCIAL RESPONSIBILITY BY PERSON OTHER THAN THE PATIENT OR PATIENT’S LEGAL REPRESENTATIVE

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I agree to accept financial responsibility for services rendered to the Patient and to unconditionally accept the terms of the Financial Agreement and Assignment of Benefits set forth above.

PATIENT CERTIFICATION

I have read, understood and fully agree to each of the above statements and have been provided the opportunity to ask questions regarding such statements. I sign below as my free and voluntary act. I also acknowledge that I have been offered information on the following subjects: Patient Rights and Responsibilities, Advance Directives, Notice of Privacy Practices, and Patient Billing. I also acknowledge that I have the right to receive a copy of this General Consent form upon my request.

Signature of Responsible Party: X	Date MM/DD/YY / /	Time 00:00 AM/PM :
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If other than Patient, indicate relationship: _____

Reason Patient is unable to sign (if applicable): _____

Hospital Representative Signature: X	Date MM/DD/YY / /	Time 00:00 AM/PM :
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