Abilene Memorial Health System

TREATMENT AUTHORIZATION AND ACKNOWLEDGMENT FORM

1. **CONSENT FOR TREATMENT:** I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending or consulting physicians, their assistants or designees. Further, I understand that among those who attend patients at this Hospital are medical, nursing, and or the health care personnel in training and volunteer student observers who, unless requested otherwise, may be present during patient care as part of their education. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by myself or my family and the Hospital shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent for these prior to them being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. **CONSENT FOR NEWBORN TREATMENT:** I request, authorize, and empower my physician(s) to make any provision for medical and surgical care of my newborn baby/babies that may be deemed necessary or advisable by my physician(s).

3. **CONSENT FOR BLOOD/BODY FLUID TESTING:** In the event that a health care worker or emergency response person(s) is suspected to have had exposure to my blood and/or body fluids or if it is likely that a health care worker or emergency response person(s) is exposed to my blood and/or body fluids, due to my illness or an uncommon rare disease, I consent to have the Hospital determine by serological testing whether or not my blood contained contagious viruses. I understand that the information obtained from such tests will only be disclosed as necessary to adequately protect my own health and the health of my family, as well as the health of those health care personnel or emergency response person(s) who may have been or become involved in my treatment.

4. **CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS:** I agree that the Hospital may utilize, destroy, or dispose of any tissues, fluids, or specimens taken from me during treatment.

5. **AGREEMENT TO PAY FOR SERVICES:** I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms.

6. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign my insurance benefits otherwise payable to me to be paid directly to the Hospital. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payments of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

7 . **MEDICARE/MEDICAID/INSURANCE BENEFITS:** I authorize the Hospital to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the Hospital for services furnished to me, and to the physicians involved for their services, including those physician/specialists doing their own billing, while I was a patient in the Hospital.

8. **PERSONAL VALUABLES/BELONGINGS:** I have, elected ______refused ______ **(Select and inital by patient or representative)** to place valuables (i.e., money, jewelry, credit cards, or other articles of unusual value, etc.) into the Hospital's safekeeping during my period of hospitalization. Dentures, glasses, hearing aids, my garments and essentially daily necessities are considered personal belongings. I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Hospital CANNOT AND WILL NOT accept responsibility for loss of any of my valuables/belonging, if they are lost or misplaced.

9. **DENTURES:** The Hospital provides denture cups for me if I require them. I will take precautions to be sure my dentures are properly kept and cared for and they will be kept in the denture cup at all times when I am not wearing/using them.

10. **AUTHORIZATION FOR DISCLOSURE TO REGULATORY OR OVERSIGHT BODIES AND WAIVER OF ACCOUNTING:** I understand that as part of its health care operations, the Hospital is required by law to disclose certain of my protected health information to public health agencies, regulatory and oversight bodies. I hereby authorize the hospital to make such disclosures without any account of such disclosures since they are required by law.

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11. **CONTRABAND WEAPONS/DRUGS:** I agree that should the Hospital find contraband weapons and/or nonprescription drugs not sold over-the-counter with my possessions, these items will be confiscated and the police will be contacted.

12. **TOBACCO PRODUCTS:** Salina Regional Health Center is a tobacco free campus. Tobacco used is prohibited on all hospital owned properties including outdoor areas, stairways, parking lots and garages, medical office building properties and entryways. Please send your smoking materials home. If you do smoke, please consider asking your nurse regarding information on smoking cessation programs.

13. **USE OF APPLIANCES:** I hereby agree that in using any and all electrical appliances in my room, not owned by or under the control of the Hospital while a patient in the Hospital, I do so at my own risk and hereby absolve the Hospital from any and all responsibility for injuries or property damage which may result from any use of said appliance.

14. **PROVIDER NONDISCRIMINATION ACT:** I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

15. **MEDICARE/TRICARE PATIENTS ONLY:** (only for acute care) A copy of "An Important Message from Medicare/Tricare" is to be completed upon each admission and a copy provided to the patient.

16. **PATIENT RIGHTS INFORMATION:** I have reviewed/received "Patient Rights and Responsibilities" and understand my rights as described in that document.

17. **NOTICE:** Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employers.

PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING

18. **CONSENT TO DISCLOSE GENERAL INFORMATION (Patient Directory) - Patient Choices (should I not indicate below, I consent for my name to be included in the patient directory):**

Initials of patient or person representative by choice:

_____ **I want my name included in the patient directory.** I understand that my name, locations in the hospital, and general condition may be provided to any person asking about me by name (including phone inquires), and to members of the clergy (including religious affiliation), my family individuals involved in my health care for disaster relief effort, or as required by law.

_____ **I do not want my name included in the patient directory.** I understand mail addressed to me will be returned and any flowers sent to me will not be delivered. Any person asking for me by name, including outside telephone calls will not be forwarded and will be told "there is no one by that name is listed in our patient directory."

19. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS and RESPONSIBILITIES:** I hereby acknowledge that I have been offered a copy of the Hospital's Notice of Privacy Practices and Patient Rights and Responsibilities.

____

(PATIENT/PERSONAL REPRESENTATIVE INITIAL)

I certify that I have read and fully understand this document and that I have received a copy of it. I, as the patient/personal representative, agree to sign this document indication that I agree with all of its terms and statements.

______________________	______________________	______________________
Patient/Personal Representative Signature	**Relationship to Patient**	**Date/Time**
______________________	______________________	______________________
Signature, Witness	**Date**	**Time**

VALUABLES PLACED IN SAFE AT TIME OF ADMISSION

Yes__________ No__________ Envelope #____________

A copy of this Document is to be delivered to the patient upon request.

Memorial Hospital
511 NE 10th Street
Abilene, Ks. 67410

Standing Order for PCR testing for COVID-19

Per K.S.A. 65-101 and 65-128, to prevent the introduction of infectious or contagious disease into this state and to prevent the spread of infectious or contagious disease within this state, a state-wide standing order for a COVID-19 test is hereby issued which would alleviate a patient from having to get an order from their health care provider and would enable the patient to obtain a test.

Symptoms:

______ Chills

______ Rigor

______ Myalgia

______ Headache

______ Malaise

______ Nausea or Vomiting

______ Congestion or Runny Nose

______ Sore Throat

______ Loss of taste or smell

______ Fever 100.4 or greater

______Diarrhea w/o alternative diagnosis

______ Upper respiratory symptoms (cough, SOB, Difficulty breathing)

______ Travel

______ Required by Employer

______ Exposure

______ Pre-op screening

Order: SARS CoV 2 RNA – COVID 19

B Holmes MD
DR. BRIAN HOLMES – Infection Control Officer

8/30/21
DATE