Consent & Conditions Of Treatment / Admission

1. CONSENT FOR TREATMENT:

I voluntarily consent to hospital care, encompassing diagnostic procedures and medical treatment at Iredell Memorial Hospital. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment at the hospital.

2. RELEASE OF MEDICAL INFORMATION:

Iredell Memorial Hospital is authorized to release my health information to health care providers, health plans and others for treatment, payment, health care operations and other purposes permitted by law. I understand that Iredell Memorial Hospital shares health information with other healthcare providers for treatment, payment and healthcare operations through electronic exchanges of information. I agree my information can be shared through each Health Information Exchange (HIE) for which Iredell Memorial Hospital is a participant. I understand that specific details regarding the HIEs, for which Iredell Memorial Hospital is a participant, are described in the Hospital's Notice of Privacy Practices and any questions I have regarding the HIEs have been answered. I further understand I can "opt-out" or withdraw consent, as applicable, from sharing my information through the HIEs. Until I follow the process to "opt-out" or withdraw consent, my information will be shared. By providing my email address below, I understand that I will receive an email on how to access my health information through Iredell Memorial Hospital's patient portal and that Iredell Memorial Hospital may use my email address for other permissible communications.

3. ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Iredell Memorial Hospital of hospital benefits otherwise payable to the policyholder including major medical insurance and payment of surgical or medical benefits directly to physicians. I authorize the refund over overpaid insurance benefits, including where policy coverages are subject to coordination of benefits. If an overpayment results from multiple payments on this admission, I authorize the hospital to deduct the amount of any other outstanding accounts I am responsible for from this overpayment.

4. FINANCIAL AGREEMENT:

The undersigned severally agree, whether signing as a patient or otherwise, that in consideration of the service rendered to the patient, payment of the accounts to Iredell Memorial Hospital and physicians is guaranteed by the patient, spouse, parent, legal guardian, etc. with the regular terms of the hospital and physicians. While any insurance or other protection related to hospital services may be hereby assigned to and payable directly to the hospital, the undersigned clearly understands that the payment obligation for the hospital bill and physician is primarily on the patient, spouse, parent, legal guardian, etc. While insurance payments received by the hospital will be applied properly to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. The undersigned also understands and agrees that the hospital charges incurred where rendered in reliance on this agreement.

5. MEDICARE-MEDICAID CERTIFICATION:

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct.

6. PERSONAL VALUABLES:

I confirm that I have been advised to send all patient funds and valuables home with a family member or have them placed in the hospital safe or other designated area for safekeeping. A hospital staff member will place valuables in a personal property envelope which includes a receipt detailing each item deposited with the hospital. This receipt will be placed with the patient chart for safekeeping. If contrary to this advice I decide to keep money or valuables, I hereby release and absolve the hospital and its personnel from any responsibility in case loss or damage occurs.

_____ Signature of Patient	_____ Signature of parent, legal guardian, or authorized representative
_____ _____ Date Time	_____ Relationship to patient
_____ Witness	_____ Signature of policyholder (if other than patient)

E-Mail Address: _____

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Iredell Health System

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