PATIENT AGREEMENT
This agreement is a universal and generic consent for Lifespan;
Any services provided by a Lifespan hospital/affiliate are covered here within.

CONSENT TO EXAMINATION AND TREATMENT

I understand that I may require medications, examinations, diagnostic procedures or other treatments in connection with my condition. I further understand that the hospital may use for diagnostic, education, quality improvement, scientific or certain research purposes or may otherwise dispose of, tissue and biologic fluids such as blood and urine, removed during such procedures. I hereby consent to the performance of such examinations, treatments, and procedures, as appropriate personnel deem necessary or advisable.

I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations in the hospital.

I understand that I have the right to withhold consent to any medical or surgical procedure. I understand that the hospital has the right to decline to permit the performance of any procedure if there is not satisfactory assurance that informed consent was given. I realize that if I withhold consent for a recommended procedure that treatment may be rendered partially or wholly ineffective.

I understand that physicians on the staff at the Lifespan hospital/affiliate may not be employees of the Lifespan hospital/affiliate.

MEDICAL EDUCATION

I understand that during my care, I may be examined and treated by physicians and other personnel in training under supervision.

PHOTOGRAPHS, VIDEOTAPES, DIGITAL OR OTHER IMAGES

I understand that photographs, videotapes, digital or other images may be taken for identification purposes or to document my medical condition or care.

PERSONAL BELONGINGS

I understand that, Lifespan cannot be responsible for my personal belongings. I have left my valuables home, or assume the risk of loss if I brought them with me to the Lifespan hospital/affiliate.

PERSONAL ELECTRONIC DEVICES

I understand that use of personal electronic devices is prohibited for patients and/or visitors in the act of taking or transmitting photographs, video recordings or voice recordings of patients, medical staff, or hospital employees without written authorization.

ACKNOWLEDGEMENT OF NOTIFICATION SECURITY CAMERA USE

I understand that security cameras are in place in certain public areas of the hospital including some patient areas.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION TO PROVIDER

I hereby authorize payment of my health insurance benefits directly to the Lifespan hospital/affiliate and to any Lifespan employed physician rendering services during this hospitalization or visit. I understand

that I am responsible for charges not covered by my insurance company and I understand it is my responsibility to meet the contract requirements of my health plan. I understand I may receive separate bills from services providing emergency care, anesthesia services, interpretation of x-rays and other diagnostic imaging, and that some physicians' services may be billed separately from hospital/affiliate services.

I understand if I request a private hospital room for my convenience, that I may be responsible for the payment of charges beyond any health care coverage I may have.

MEDICARE AUTHORIZATION

To the extent I am covered by Medicare, I agree to the conditions of admission for hospitalization outlined in this agreement. I certify that all the information I provided in connection with my application under the Medicare Program (Title XVIII of the Social Security Act) is correct. I request that payment for any authorized Medicare benefits to be made on my behalf be made to the hospital or its employed physicians. I authorize any holder of medical information or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine my entitlement to these Medicare benefits or benefits for related services.

If I am not the patient, I certify that I am authorized to agree to these Conditions of Admission on the patient's behalf.

RIGHT TO ADVANCE DIRECTIVES

I have been given written information on my right to make medical decisions and to have advance directives (in the form of a living will or Durable Power of Attorney for Health Care). I understand that it is my responsibility to provide the hospital with a copy of my advance directive, and that failure to do so may mean my wishes are not known to my providers. I understand that my advance directive will be handled with appropriate sensitivity and confidentiality and that I will be provided with the same quality of care whether or not I have an advance directive.

FINANCIAL RESPONSIBILITY

I agree, in order for Lifespan to service my account or collect any amounts I may owe, Lifespan may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

I authorize the Lifespan hospital/affiliate to apply any outstanding credit balance I may have on my account to satisfy to the fullest extent possible any outstanding account balances) I may have with any other Lifespan hospital(s)/affiliate(s) before processing any patient refund to me.

ACKNOWLEDGMENT

I certify that I have read the above and it has been explained to me so that I understand. I certify that I am the patient the parent/guardian of the patient or am duly authorized by the patient as his/her general agent to review the above and to accept its' terms.

_____

Patient

_____ _____

Patient’s Guardian Patient’s Agent/Representative