Union Memorial Hospital
201 East University Parkway
Baltimore, MD 21218-2895
Experience Matters
MedStar Health

CONSENT FOR MEDICAL TREATMENT - B

CONSENT TO HOSPITAL CARE / TREATMENT AND HOSPITAL ADMISSION: It is understood and agreed upon that the undersigned patient is suffering from a condition requiring medical treatment and hospital care. The patient consents to hospital care encompassing emergency treatment, hospital admission, routine diagnostic procedures and medical treatment for the patient. Any obstetrics patient will be screened, stabilized and transferred for any necessary obstetrical admission. If delivery should take place in the emergency department, I consent to have my baby cared for until transfer is arranged.

RELEASE OF INFORMATION: I authorize any physician hospital, pharmacy, insurance company, employer or organization to release any information regarding the medical history, treatment, or benefits payable for this claim to any organization responsible for payment of this claim or to any physician or medical service organization who will render care to the patient after discharge from Union Memorial Hospital.

NOTICE OF PRIVACY PRACTICES: My initials acknowledge that I am in receipt of the MedStar Privacy Practices Brochure: _____ *Initials*

PHYSICIAN CHARGES: I understand that in addition to any bills I may receive pertaining to facility (hospital) charges, I may also receive bills on behalf of the physicians who participate in my care. These physician charges are not included in the bill from the hospital. (Note: when verifying your insurance coverage for your hospital stay, please verify your coverage for the physician groups that may contribute to your care.)

RESPONSIBILITY FOR PROPERTY OR OTHER VALUABLES: The hospital shall not be responsible for the loss or damage to any personal property of the patient brought in the hospital.

AGREEMENT TO PAY FOR SERVICES: For and in consideration of services rendered or to be rendered to the aforementioned patient, I/we agree to pay Union Memorial Hospital and any physician or contracted physician group providing treatment or services to me in the hospital in full for said services.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION ***(Applies to Medicare Patients Only)***: I hereby certify that the information given by me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payors is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby authorize this hospital to use my sixty (60) Lifetime reserve days Medicare coverage. I have received *An Important Message from Medicare.*

GUARANTEE OF PAYMENT: I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay the hospital's charges in full when rendered. I also acknowledge that interest may be charged to unpaid balances over thirty (30) days from the date payment is due. In the event that the account is referred to collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment to this hospital of any insurance, personal injury, or other benefits otherwise payable to me or the patient. The undersigned acknowledges the responsibility for any coinsurance, deductible or other amount not received by the hospital from any third party source.

PATIENT OR RESPONSIBLE PARTY NAME (Printed)	PATIENT OR RESPONSIBLE PARTY NAME (Signature)	RELATIONSHIP TO PATIENT
ADDRESS	WITNESS	DATE 1/5/18 TIME 1058
CITY STATE ZIP CODE	REASON IF UNABLE, MINOR (UNDER 18), PHYSICAL CONDITION, OTHER	

ADVANCE DIRECTIVES: The patient service representative or the nurse doing the admission work up will read to the patient or family member and obtain the following information to comply with the patient self determination act. Hospitals must be responsible for documenting in each individual's medical record whether they have executed a living will or medical power of attorney.

☐ Yes ☑ No ☐ Don't Know	Does the patient have an advance directive for medical care or a living will?
☐ Yes ☑ No ☐ Don't Know	Has the patient named an agent for health care decisions in an advance directive? If yes, who is the agent? _____
☐ Yes ☑ No	If yes, the patient / family has been requested to provide a copy of the advance directive or living will to the hospital for the medical record.
☐ Yes ☑ No	If you do not have your Advanced Directive with you, would you like your doctor to document your directives in your medical record?
☐ Yes ☑ No ☐ Don't Know	Does the patient have a signed organ donor card?
☐ Yes ☑ No	Patient has received information about the patient advance directives.
☑ Yes ☐ No ☐ Not Applicable	If no, patient was given information about advance directives.
☐ Yes ☐ No	Patient was given available resources for additional information.

If patient want to discuss their advance directives refer them to the attending physician. For general information about advance directives, the patient can be referred to social work or patient relations.

Tanya Ross — 1/5/18

HOSPTIAL STAFF SIGNATURE — DATE

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