THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

DOB: [redacted]
MRN: [redacted]
CSN: 2023681032
HAR: 2000251355
DATE: 6/29/2017

2023681032

Consent for Treatment, Authorization to Release Medical Information, Assignment of Insurance Benefits for Hospitals and Physicians, and Patient Self Determination Act Checklist

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize University of Mississippi Medical Center or my attending physician or any contractor on behalf of University of Mississippi Medical Center to release or disclose information from my hospital medical record pertaining to this hospitalization, in accordance with the policies of this hospital, to insurance companies and/or hospital benefits programs as needed to process this claim.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign payment directly to University of Mississippi Medical Center and/or to my physicians, benefits payable to me but not to exceed the hospitals or physicians regular charges for this period of hospitalization. I understand that I am financially responsible for charges not covered by this authorization.

FINANCIAL AGREEMENT: For services rendered, I, the undersigned, agree to pay all professional and hospital charges not covered by insurance. I also agree to pay all attorney and/or collection fees necessary for the collection of payment.

MEDICAID PATIENT CERTIFICATION: I certify that I am a recipient of the Medicaid Title XIX program and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the Division of Medicaid any requested information concerning medical, insurance and financial records related to my hospitalization. I assign the benefits payable for services rendered to the physicians or organization furnishing such services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act 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 request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services rendered to the physicians or organization furnishing such services.

NOTICE TO BENEFICIARIES OF COINSURANCELIABILITY: When services are provided in hospital departments, the beneficiary will receive a hospital bill and will receive bill(s) from any physician providing professional services. The beneficiary/guarantor will be responsible for coinsurance amounts relating to services billed by the hospital and for coinsurance amounts relating to services billed separately by the physician(s). When services are provided in private physician offices or other non—hospital clinics, the beneficiary is responsible only for coinsurance amounts relating to charges billed by the physicians.

CONSENT FOR TREATMENT: The undersigned authorizes physicians and University of Mississippi Medical Center to furnish medical and surgical treatment deemed appropriate including intravenous solutions, blood transfusions, local, general, and regional anesthetics, antibiotics or other drugs deemed necessary. I am aware that adverse unforeseen reactions can occur and may even result in death. I authorize the hospital and my physicians to take photographs, video, audio, or other images or recordings of me or parts of my body while under the care of the hospital for use in medical evaluation, performance improvement, education or research. I further understand that my identity will be concealed and my privacy maintained if the material is used for educational purposes.
I hereby authorize The University Hospitals and Health System and its medical staff: to preserve, use or disclose, or share for scientific or teaching purposes, including research; to use in grafts or transplants upon living person(s); or to otherwise dispose of dismembered tissue, blood, saliva, parts and the like.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge I have been informed of the Patient Rights and Responsibilities and understand that a printed copy is available to me at my request.

RETIREMENT/DESTRUCTION OF X---RAYS: I hereby authorize University of Mississippi Medical Center to follow the usual hospital practice of retiring x---ray films and any other graphic data which may be generated during patient's hospitalization four (4) years after they are generated if a report of the findings is retained for the same period as other hospital records. Further, I hereby release and hold harmless University of Mississippi Medical Center, its officers, staff and employees, from any liability connected with this procedure.

VALUABLES: The undersigned hereby releases the hospital from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

PATIENT SELF	Has the patient executed an Advance Directive?	☐ YES ☐ NO
	Has the Advance Directive information been provided to the patient?	☐ YES ☐ NO
DETERMINATION ACT	Is the Advanced Directive in the patient's medical record?	☐ YES ☐ NO
	Do you want to discuss Advanced Health Care Directives with someone?	☐ YES ☐ NO

[redacted]
Signature of Patient or Guardian / Date

Signatur[redacted]

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