WOODS [redacted] 05/04/55 62

F EMERGENCY DEPT SVH

Saint Vincent Hospital

# Conditions of Treatment Agreement

*Please Note: Page 3 of this document is filed in the Medical Record
Pages 1 and 2 can be retrieved in the electronic record.

MCRACUTE

## Consent to Medical and Related Health Care:

1. I understand that my health insurance may not cover all of my health care costs. It will only pay for covered benefits that are covered under my insurance plan.
2. I understand that when I receive an item or service, that is not a part of my health care plan, I am responsible to pay for it. personally or through any other insurance that I may have. I understand that I I will be liable for all costs of my care and/or services that I receive, except for those services for which I am eligible to receive under my insurance plan.

Some items my Insurance may not pay for:
1. Transportation, including ambulance and/or chair van that has not been authorized by my insurance plan.
2. Services that are determined to be Non Covered according to my insurance plan.
3. Any deductibles or co-payments associated with my services and care.

By signing, I acknowledge that: (1) I read this Agreement: (2) I have had any unclear or ambiguous items explained to me; and (3) I understand its contents and accept the terms;
(4) I would___would not___like a copy of this document.

[redacted]
Patient Signature

4-6-18 - 11:43 AM
Date and Time

[redacted]
Witness Signature

11:43 AM
4-6-18
Date and Time

**********

Patient Did Not Sign because [Check One or More]:
__ Patient's Medical Condition
__ Patient not present at registration
__ No family member/Personal Representative present
__ Minor
__ Transfer from another facility
__ Other_____

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If signed by someone other than patient:

I. _____ [Print Name]: (1) read this Agreement: (2) have had any unclear or ambiguous items explanined to me: and (3) understand its contents and accept the terms on behalf of _____.
Patient's Name

_____ _____ _____
Signature of Patient's Representative Relationship to Patient Date and Time

_____ _____
Witness Signature Date and Time

2nd Attempt to obtain Patient's Signature

Patient Did Not Sign because [Check one or More]:
__Patient's Medical Condition
__Patient not in room
__No Family / Personal Representative
__Other_____

_____ _____
Signature PAS Staff Date and Time

## Saint Vincent Hospital
# Consent for Medical, Surgical and Diagnostic Procedures

Patient's Name: _____

**We would like you to receive all the information you need to make the best decisions about your healthcare while you are at Saint Vincent Hospital. You have a right to be informed about the nature and purpose of the proposed procedure(s), risks and consequences of the procedure(s), risks and prognosis if no treatment is rendered, the probability that the proposed procedure(s) will be successful and alternative methods of treatment (if any) and their associated risks and benefits. You also have a right to be informed when practitioners other than your doctor will perform important parts of the procedure(s). If you need an interpreter to help you understand the information discussed, this service will be provided for you. This informed consent document summarizes the important pieces of information that your doctor has discussed with you in detail.**

Name of the Procedure: _____

Purpose of the Procedure: _____

Name of the Provider Performing the Procedure: _____

**Risks / Benefits and Alternatives to Treatment** ☐ See attached addendum for specific procedure related information

[redacted]

**Practitioners other than your doctor will perform/supervise a part of your procedure(s)** ☐ Not Applicable

| **Any one of the following practitioners** | **Identify the portion of the procedure this person will perform** |
|---|---|
| ☐ Resident / Fellow ☐ Physician Assistant<br>☐ Nurse Practitioner ☐ Nurse Midwife<br>☐ Other: _____ | ☐ Will assist throughout the procedure<br>☐ Or will be restricted to: _____ |
| ☐ Resident / Fellow ☐ Physician Assistant<br>☐ Nurse Practitioner ☐ Nurse Midwife<br>☐ Other: _____ | ☐ Will assist throughout the procedure<br>☐ Or will be restricted to: _____ |

☐ **If applicable:** I am aware that an implantable device will be placed. I agree to the release of my Social Security number in order to identify my device in the event of a product recall. S.S. #: _____ - _____ - _____ Signature: _____

☐ **If applicable:** I authorize the administration of blood or blood products as deemed medically necessary by my physician. I have been made aware of the risks and consequences that can be associated with transfusions of blood products. I understand that there may be alternatives to allogenic (Blood Bank) blood transfusion and that each of these alternatives has its own risk.

☐ **If applicable:** I authorize the administration of Procedural Sedation. I have been made aware of the expected results (reduced anxiety and pain, partial or total amnesia), risks (an unconscious state, depressed breathing, impaired consciousness, aspiration pneumonia), and technique (drug injected into blood stream to provide relaxation).

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**I understand that it is my right to be fully informed about the procedure(s) to be performed in order to make an intelligent and reasonable decision whether to undergo the procedure. However, I also understand that all procedures involve some risk. I have been reasonably and adequately informed of the risks of the procedure including not having the procedure, and no promise or guarantee of a specific result has been made to me. In signing this document, I acknowledge that I have read this document and understand its content. The provider signing this document has fully explained the content of this document and answered all of my questions to my satisfaction. If an interpreter was present, the content of the document and the conversation with the provider were translated to my satisfaction. Therefore, I consent to having the stated procedure performed. I also consent to the disposal of any tissue removed during this procedure.**

Patient's Signature: [redacted] Date: 4/13/18 Time: 0758

State why patient is unable to sign: _____

Person Signing on Behalf of Patient: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian ☐ Health Care Proxy ☐ Other: _____

Witness's Signature *(optional if signing in person)*: _____ Date: _____ Time: _____

Provider's Signature: [redacted] Date: 4/13/18 Time: 0758

Interpreter Service Provided by: _____