MOLOKAI GENERAL HOSPITAL
CONSENT FORM FOR OUTPATIENT & INPATIENT SERVICES

CONSENT FOR TREATMENT – I authorize and consent to medical care and treatment at Molokai General Hospital (MGH) which my treating physician and medical providers find to be necessary and which is given or performed at their direction. I understand that any requests or restrictions related to my treatment must be discussed with my treating physician.

LEGAL RELATIONSHIP BETWEEN PHYSICIANS AND MGH – Some of the physicians and services providing care to me at MGH are independent contractors who are not employees or agents of MGH. These independent physicians are private care physicians and use their own clinical judgement in deciding how best to care for me. MGH staff, including nurses and technicians, carry out their orders and instructions. Independent contracted services include interpretation of X-ray, ultrasound, and CT scans (Radiology Associates) and Pathology (lab) services (Diagnostic Laboratory Services, Inc). I acknowledge that MGH bills only for charges incurred for hospital and services in the Emergency Department. The independent physicians will bill me separately for their professional services as well as Radiology Associates and some of Diagnostic Laboratory Services. I also acknowledge that my primary care provider may receive copies of information regarding my visit unless I specifically request in writing that they not receive it.

FINANCIAL AGREEMENT – I understand that I am responsible for paying my MGH bill in full within 90 days (or longer if required by law), unless I make other arrangements with the MGH Business Office. I also agree to these additional terms:

Late Payment Charge: A late payment charge of 1% per month, calculated at simple interest, may be assessed on all accounts not paid in full within 90 days (or longer if required by law)

Collection: If the bill is not paid in full within 90 days (or longer if required by law or other arrangements have been made), I will be responsible for paying all fees and other costs incurred to collect my bill

Medicare Coverage: I certify that the information given by me in applying for payment under Medicare is correct. I understand that the Social Security Administration may release information on my Medicare effective dates and Medicare Claim Number to MGH. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries information needed for this or any related Medicare claim. I request that payment of benefits be made to MGH on my behalf.

Assignment of Insurance Benefits and Payments: I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all of these benefits to MGH toward payment of my bill and direct my insurance carrier to pay these benefits to MGH. MGH will bill my insurance carrier if I provide the appropriate information in a timely fashion.

RELEASE OF SPECIALLY PROTECTED HEALTH INFORMATION

_____ (Please initial) I understand that certain specific categories of my health information require my consent before release. If my medical records for this admission and/or course of treatment contain any information related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), mental health, alcohol and/or substance abuse diagnoses and treatment, I consent to release such health information for the purpose of treatment, obtaining payment from my insurers and other payors and for other specific insurer/payor requirements within the limits of the law.

RELEASE OF INFORMATION TO THE GENERAL PUBLIC & MEDIA
Please initial one (1) of the following options to determine how you would like information about you, or your family member released.

_____ PENDING (P): MGH may release information to family for notification purposes. Treat as NO INFO for release to public & media.

_____ REGULAR (R): MGH may release condition and/or location to those who ask for you by name.

_____ LIMITED (L): MGH may acknowledge that you are here only.

_____ NO INFO (NI): MGH may not release any information or acknowledge that you are here.

NOTICE OF PRIVACY PRACTICES – My signature below will confirm that I have been given a copy of the MGH Organized Health Care Arrangement Notice of Privacy Practices. I certify that I have read this Consent and that I am the patient, or the patient's authorized representative. On my own behalf (and on behalf of the patient) I accept and agree to be bound by this Consent. A copy will be made available to me upon my request.

X_____ Date: _____ Time: ____:____ am / pm
Signature of Patient

X_____ Date: _____ Time: ____:____ am / pm
Signature of Patient's Representative

_____ X_____
Relationship to Patient MGH Representative

If the patient is unable to sign and/or has no known representative document below

Signed: _____M.D. Date & Time: _____

Signed: _____R.N. Date & Time: _____