____
Patient Name (Please Print)

CONSENT TO HOSPITAL/CLINIC AND MEDICAL TREATMENT

MEDICAL CONSENT: I, knowing that I, have a condition requiring hospital/clinic or medical care, do hereby voluntarily consent to such care encompassing routine diagnostic procedures and medical treatment by my physician, his/her assistants, or his/her designees, including hospital/clinic personnel, as is determined necessary in his/her judgment. I am aware that the practice of medicine 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 Thayer County Health Services Hospital and/or Clinic. This consent is designated to cover all procedures in the hospital and clinic which do not require a specific consent form.

NARCOTTICS, DRUGS OR MEDICINES: My use of any narcotics, drugs or medicines will be subject to hospital or clinic control, and I agree that all such narcotics, drugs or medicines will be kept in the hospital/clinic's possession to be dispensed in accordance with the hospital/clinic's rules or regulations.

PRESERVATION OF TISSUE: I hereby authorize Thayer County Health Services to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

AUTHORIZAITON FOR RELEASE OF MEDICAL INFORMAITON: I hereby authorize Thayer County Health Services to furnish to the insurance carrier(s) or their agents identified on the facesheet attached to this form such information as it or they might need to request concerning my present treatment in the hospital or clinic. I also authorize Thayer County Health Services to provide my insurance carrier verbal/written communication, reports or other data prepared by the Utilization Review Committee personnel concerning my present treatment. I further authorize Thayer County Health Services to advise my insurance carrier(s) if and when it is determined by the Utilization Review Committee that I no longer require acute care. I agree to the transfer of medical information t o the health care provider(s) or facility that will provide continuation of my health care. A photocopy of this authorization shall be considered as valid as the original.

ASSIGNMENT OF BENEFITS: I hereby authorize and assign payment directly to Thayer County Health Services hospital and clinics any insurance benefits relative to this service. I also understand I am responsible for any amount not covered or paid by my insurance benefits authorized by this assignment.

CONFIDENTIALITY: I understand that the hospital/clinic will endeavor to protect the confidentiality of my medical records, however, the hospital/clinic shall not be liable by reason of its release of said records or any part thereof when responding in good faith to an apparent valid request. I also understand that I may review and copy my medical records at my own expense and that this review shall take place in the Medical Records Department during regular business hours.

PLEASE COMPLETE FOLLOWING QUESTIONS ONLY IF YOU HAVE MEDICARE

Yes	No	
____	____	1) Are you entitled to Black Lung Benefits or VA service card?
____	____	2) Is your visit due to an accident? If so, did the accident happen _____at work, _____at home, _____auto
____	____	3) Are you covered under group health insurance?
____	____	4) Are you employed? If not/retirement date________________________
____	____	5) Is your spouse employed? If not/retirement date_________________________
		6) Please check reason you are eligible for Medicare: ___age 65 or over, ___disabled, ___end stage renal disease

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THIS FORM HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

_______________________________ _______________________________
Date Patient's Signature

If the patient is unable to consent or is a minor, please complete the following:

____
State reason patient is unable to consent

_______________________________ _______________________________
Signature of Parent, Legal Guardian, Authorized Representative Relationship to Patient

____
Witness

(Please see Motor Vehicle Accident and Worker's Compensation Injury Questions on Reverse)

COMPLETE ONLY IF IT WAS A MOTOR VEHICLE ACCIDENT

____

Name of company Address City State Zip

Date of accident_____________________________ Date must be completed in order to bill_______________

Is this your insurance company? _____ Yes _____ No Attorney's Name _________________________

COMPLETE ONLY IF IT WAS A WORK RELATED INJURY

1. Employer at time of injury ____

   ____

   Name Phone Supervisor/contact person

   ____

   Address City State Zip

   *****COMPLETE ADDRESS & DATE MUST BE COMPLETED IN ORDER TO BILL*****

2. Date of accident____________________ Have you missed work? _____ yes _____ no
3. Date you last worked_____________________ Are you on light duty? ____ yes ____ no
4. Location of accident: ____
5. Explain briefly how the injury occurred ____

   ____
6. Do you have a casemanager? _____ yes _____ no

   ____

   Name Company name

   ____

   Address City State Zip Phone Claim no.
7. Work comp carrier for billing – if not employer ____

   ____

   Company name Address City State Zip
8. Are you represented by an attorney? _____ yes _____ no

   ____

   Attorney Name Address City State Zip
9. Are you covered by group health insurance? _____ yes _____ no