Patient Information

CONDITIONS OF ADMISSION AND CONSENT FOR MEDICAL SERVICES

CONSENT FOR MEDICAL SERVICES: I present myself for medical services at Baptist Medical Center South, Baptist Medical Center East or Prattville Baptist Hospital, hereinafter "Baptist Health". I consent to such care as my physician orders and all other persons caring for me deem necessary and beneficial. I understand that this care may include physical examinations, diagnostic testing to include blood draws and/or radiologic procedures, repair of lacerations if required, and other needed/identified medical/surgical procedures. The issue of consent is rising to new heights and previous simple language is no longer being accepted as broadly consenting to these procedures. I also understand that such treatment may involve risks and that no guarantees have been made to me about the outcome of this care. I understand that the physicians on the staff are independent contractors, and not employees or agents of Baptist Health. I understand that I have the right, in collaboration with my physician(s), to make decisions involving my health care and to accept care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal. I consent to the taking and publication of any photographs or videotape recordings taken in the course of operation for the purpose of advancement of medical knowledge, and I understand that the same are the property of the treating/operating physician surgeon.

PERSONAL VALUABLES: I have been asked/advised to either deposit with the business office or otherwise send home all valuables, including but not limited to money, jewelry, rings and watches. I understand that should I choose to retain some with me, that Baptist Health cannot be responsible for them and I hereby release Baptist Health from any responsibility for the loss of my retained valuables.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I hereby authorize payment of all insurance benefits, basic and major medical, for this period of medical emergency and/or diagnostic treatments to be made directly to the Baptist Health hospital rendering care, and to all entities contracted with Baptist Health to perform services. I understand that I am financially responsible for all charges not covered by insurance payments, including private room differentials, and that all efforts for collection of those benefits are for my convenience and do not represent a guarantee for collection or a credit to my account until such time as payment is received by Baptist Health and the contracted entities. I also assign the benefits payable for physician services rendered to me to the physicians or physician group to submit a claim to my insurance company(ies), Medicare and/or Medicaid. I will be responsible for any collection fees, court costs and/or attorney fees incurred while collecting on my account(s). For the purposes of acknowledging this assignment, a copy of this original consent shall be as valid as the original.

You authorize us/agent to call you at any number you provide or at any number at which we reasonably believe we/agent can contact you, including calls to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charge(s) that you may incur for incoming calls from us/agent, and/or outgoing calls to us/agent, to or from any such number, without reimbursement from us/agent.

COMMITMENT TO A SAFE ENVIRONMENT: We have a responsibility to protect the safety of our patients, visitors, and employees. If criminal activity occurs we intend to take appropriate action.

IMPORTANT MESSAGE ABOUT MEDICARE INPATIENT RIGHTS - ACKNOWLEDGMENT OF RECEIPT:
I have received a copy of CMS's Important Message About Inpatient Medicare Rights.
NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT OF RECEIPT:
I have received a copy of Baptist's Notice of Privacy Practices.
PATIENT SAFETY BROCHURE / PATIENT HANDBOOK - ACKNOWLEDGEMENT OF RECEIPT:
I have received a copy of the Patient Safety Brochure and/or a copy of the Patient Handbook

PATIENT INFORMATION DISCLOSURE:
1. ❑ I opt out of the hospital directory ❑ I want to be in the hospital directory

2. While hospitalized, my medical / health information may be released to only (check all that apply):

❑Spouse ❑Other relative(s) ❑Personal representative

❑Members of immediate family ❑Close personal friends ❑None

Witness: _____ Patient or Responsible Party: _____

Date/Time: _____ Legal Guardian / Proxy: _____

Reason patient signature was not obtained:_____

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