

**Culpeper Regional Hospital
CONSENT FOR TREATMENT FORM**

Consent: I _____, hereby voluntarily consent to my admission to and/or treatment by CULPEPER REGIONAL HOSPITAL (the "Hospital") and to rendering of such care and medical treatment as may be deemed necessary by my attending physician(s), or by his consultants, associates, or designees or by any employee personnel or agent of the Hospital who may carry out part or all of my treatment. The Hospital services and care to be provided may include diagnostic procedures and such other medical treatment as my attending physician(s) may consider necessary. I understand that during the course of my admission and/or treatment, persons who are not employees of the Hospital, but who have authorized by the Hospital's Medical staff to provide specific health care services, may provide treatment to me.

CONDITIONS:

- **RELEASE OF INFORMATION:**
- I authorize my physician(s) to release to the Hospital information concerning any subsequent care provided, which may be related to any treatment I receive in the Hospital.
- This consent form will be stored as defined by hospital policy.
- **USE OF SPECIMENS AND TISSUES:** I hereby authorize the Hospital to retain, photograph, preserve, and use for scientific or teaching purposes, or dispose of at its convenience any specimens, or tissues taken from my body during my hospital procedure or treatment.
- **ADVANCE MEDICAL DIRECTIVES/DO NOT RESUSCITATE ORDERS:** I have received information about the patient's rights and responsibilities regarding health care decision-making and the use of Advance Directive and the availability of a patient representative to assist me in this regard. While I am a patient at the Hospital or am receiving treatment from the Hospital, I understand that if my heart stops or I stop breathing, efforts will be made to make my heart or breathing start again unless my physician writes an order that I am a DO NOT RESUSCITATE patient, or that further attempts to make me live would be futile. I understand that I have the right to speak with my physician about my wishes in this regard. I further understand that it is my responsibility to provide the Hospital or my physician with documents concerning advanced medical decision making such as living wills, powers of attorneys or advanced medical directives.
- **NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B AND HEPATITIS C BLOOD TESTING:** I understand that Virginia Code §32.1-45.1 authorizes health care providers to test patients for HIV antibodies, Hepatitis B and Hepatitis C when the health care provider or any person employed by or under the direction and control of the health care provider is exposed to the body fluids of a patient in a manner which may transmit blood-borne diseases, human immunodeficiency virus (HIV), Hepatitis B and C. Pursuant to the law, in the event of such exposure, I will be deemed to have consented to such testing, and to have consented to the release of the tests results to the health care provider who may have been exposed. Positive test results will also be disclosed as medically necessary for my treatment or as required or permitted by law. I understand that I will be given an opportunity to have appropriate counseling in connection with such test results.
- **NO GUARANTEE:** I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me or otherwise implied regarding the results of my treatment or examination in the Hospital.
- **CONTENT OF FORM:** I have read the information provided in this form in its entirety and have been given an opportunity to ask questions. I agree to the terms contained in this form and acknowledge that the terms cannot be changed or modified, except in writing signed by an officer of the Hospital. I certify that the foregoing information, and all supplied by me as a part of the admission process, is correct.
- **SAFEKEEPING OF VALUABLES:** I understand that the Hospital will not be responsible for any valuables or other such property left unattended in the Hospital. I have also been advised that the Hospital will provide safekeeping for small items of valuable personal property upon request. Accordingly, I assume the risk of loss or theft of any personal property not deposited with the Hospital for safekeeping and agree to hold the Hospital harmless from any all liability, which may result from the loss of any such personal property. The Hospital reserves the right to dispose of personal property deposited with the Hospital for safekeeping if not claimed by the owner within (30) days of the date of discharge.
- **ASSIGNMENT OF BENEFITS:** In consideration of medical services to be rendered to me or at my request, I assign to the

- Hospital, and to any physicians and other health care providers rendering care to me, to the extent necessary to satisfy any outstanding indebtedness, all sums payable to me or on my behalf pursuant to any health benefit plan, policy of insurance (including, but not limited to, health, liability, uninsured motorist or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused the admission or medical treatment. As such payments for Hospital services, and/or physician services, and other health care provider services shall be made directly to the appropriate party previously listed. I understand that neither the Hospital nor any other health care provider has any obligation to collect benefits covered by this Assignment other than benefits payable by a health maintenance organization. Hospital is hereby authorized to act as attorney-in-fact in the collection of benefits from any third party through whatever means may be deemed necessary and in the endorsement of checks made payable to patient and/or the Hospital.
- **APPLICATION OF CREDIT BALANCE:** Credit balances which occur in my favor on this account for whatever reason may be applied by the Hospital to reduce any other outstanding account with the Hospital which I am responsible before refund of any balance remaining.
- **COORDINATION OF BENEFITS:** I hereby authorize the refund of overpaid insurance benefits in accordance with any services are provided by the Hospital, which are subject to a coordination of benefits clause.
- **NON-MEDICARE PATIENTS-RESPONSIBILITY FOR PAYMENT OF THE BILL:** In return for services rendered to the patient or any infant(s) born to the patient, I understand that I owe, and unconditionally agree and promise to pay, the Hospital the full amount charged for these services. I specifically agree to pay for any services, which are determined not to be covered by any health benefit plan or insurance company. I am aware that I am not relieved of liability by any extension of time granted for the payment of these charges, not by the acceptance by the Hospital of a note of the patient or any third person. I also waive the homestead and all other exemptions. The Hospital reserves the right to charge interest at the rate of twelve percent (12%) per annum or one percent (1%) per month for outstanding balances remaining after the normal billing cycle has been completed. If the Hospital requires legal assistance to collect an account, I agree to pay the cost incurred for such collections, including without, limitation, an attorney fee equal to twenty-five percent (25%) of all sums due on account. I authorize the Hospital to check my credit and employment history and by this authorization expressly permit sources and employers to provide the Hospital with all information requested.
- **MEDICARE PATIENTS ONLY:** I request that any of my authorized Medicare benefits for any services furnished to me by or in the Hospital be paid. I authorize any holder or medical and other information about me to release to Medicare and its agents any information needed to determine these benefits. I understand that I am responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.
- **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I have a received a copy of the Notice of Privacy Practices and understand that the notice describes how my medical information may be used and how I can get access to this information. I have also been given an opportunity to ask questions about the information provided in the Notice.

SIGNATURES:

Print Name (Patient)

Signature of Patient or Legal Guardian

Date

Other person executing form and relationship to patient.

Hospital Representative:

Date

(If written acknowledgement of receipt of the Notice of Privacy Practices is not obtained, complete the following):

Written acknowledgment was not obtained for the following reason(s) _____