Little River Healthcare Consent / Authorization Form **Form to be completed by the responsible party**

Previous Medical Care:

Have you been in the hospital in the last 60 days?	□ Yes	□ No
Is there a possibility that you could be pregnant?	□ Yes	□ No
Are you an Organ Donor?	□ Yes	□ No
Do you have an Advanced Directive?	□ Yes	□ No

Current Medical Care: Is this visit the result of an accident? □ Yes □ No □ Auto □ Other_____

Authorization for Care: I grant permission to the employees of Little River Healthcare to examine, treat, and perform diagnostic tests and procedures that my provider deems necessary.

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Initials

Authorization of Care by ANP/PA: I understand that my care may be provided by an Advanced Nurse Practitioner or Physician Assistant in consultation with a physician. Arrangements will be made for referral to a physician if medically indicated or at my request. My signature on this form constitutes my consent to treatment by this professional.

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Initials

Assignment of Benefit: Insurance Assignment: In consideration of services rendered or to be rendered, I hereby assign and transfer to Little River Healthcare any benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered. This assignment includes insurance benefits accruing to me from uninsured motorist coverage.

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Initials

Financial Agreement & Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Little River Healthcare may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this assignment and / or not paid by said companies and payors.

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Initials

Non-Smoking Facility: I understand this is a non-smoking facility and I will abide by this policy.

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Initials

Valuables: I understand that Little River Healthcare is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of and not replaced by Little River Healthcare.

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Initials

Photography/Imaging: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Little River Healthcare will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Little River Healthcare's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

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Initials

HIV, HBV and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1)if donation of blood, blood products, organs or tissues is contemplated; (2) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV & HCV testing under any of the above situations.

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Initials

Privacy Practices Little River Healthcare is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to protected health information. I have been given the opportunity to review the notice of privacy practices.

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Initials

Please indicate the appropriate response as it pertains to how we may contact and leave messages for you:

Home telephone, answering machine or voice mail	□ Yes	□ No
Cell Phone and/or Voice Mail	□ Yes	□ No
Work Phone, answering machine or voice mail	□ Yes	□ No

Authorization to Release Information: I authorize Little River Healthcare to release information requested by insurance companies, review agencies or other third party payers for payment of claims arising out of this visit.

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Initials

Please list the names of authorized individuals that can receive protected health information: _____

_____ _____ _____

Signature of Patient: Date & Time Signature of Patient's Representative (if applicable)

_____ _____

Relationship to Patient: Reason patient unable to sign

Place Sticker Here