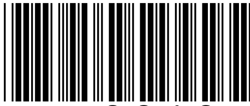

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CONSENT TO TREATMENT

Check (✓) Facility:

☐ CHI Health Clinic	☐ CUMC-Bergan Mercy	☐ CUMC-University Campus	☐ Good Samaritan	☐ Immanuel
☐ Lakeside	☐ Mercy Corning	☐ Mercy Council Bluffs	☐ Midlands	☐ Missouri Valley
☐ Nebraska Heart	☐ Plainview	☐ Schuyler	☐ St. Elizabeth	☐ St. Francis
☐ St. Mary's	☐ Other: ____________________			

Consent to Treatment: I have a condition requiring examination, diagnosis, and treatment and hereby consent to and authorize such customary care including but not limited to x-ray, laboratory, routine diagnostic tests and therapeutic procedures ("Services") performed by my admitting and treating physician(s), which may or may not be employed by the hospital and his or her assistants or designees, including personnel employed by CHI Health. I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I Consent to this and for CHI Health to retain ownership rights to these images. A separate consent for photography form will be obtained for disclosure of any images outside of CHI Health that identify me and are used for purposes such as education and marketing. I understand that such care may involve risks and that no guarantees have been made to me concerning the results of this treatment or examination. I further understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures/treatment. For any notice or authorization referenced herein a copy of this form can be used in place of the original.

Clinical Education and Research: I agree to the supervised participation of health care learners (e.g., medical students, nursing students, interns, residents, fellows, non-physician clinical students, etc.) in my care. I understand that patient records and specimens obtained from my body for medical care purposes may be retained and used for educational and research purposes in accordance with applicable regulations. Tissue shall be disposed of in accordance with the hospital's usual and customary practices.

Independent Status of Physicians: I recognize that not all physicians, and health care providers including, but not limited to, Certified Registered Nurse Anesthetists, Radiologists, Emergency Medicine physicians, Anesthesiologists, Physical, Occupational and Speech Therapists, residents or medical students (under the supervision of physicians and/or residents) who provide Services to me during this admission are employees or agents of CHI Health. Such individuals are INDEPENDENT CONTRACTORS who are granted privileges to use CHI Health Facilities for private Patients and bill separately for their Services. In addition, I understand that CHI Health is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors.

Assignment of Facility Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to CHI Health and authorize direct payment to CHI Health. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Assignment of Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to all physician(s) and/or medical professionals providing services to me and authorize direct payment to physician(s). This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize CHI Health, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by CHI Health.

Financial Responsibility: I understand that I am financially responsible to CHI Health as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, out-of-pocket expenses, or the extra cost of a private room in which I am placed at my own request. I authorize CHI Health or physician(s) to access and review my credit report for purposes related to billing or collection of accounts payable to CHI Health or physician(s).

Communications Consent: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving health care services.

Advance Instructions for Health Care: I understand that I may indicate in writing (Advance Directives, i.e. Living Will and Durable Power of Attorney for Health Care) my desire to receive, select and/or define medical or surgical treatment or choose non-treatment. CHI Health will recognize such instructions in accordance with applicable state law and CHI Health policies if either or both Advance Directive statements(s) are provided to CHI Health so that a copy can be filed with my medical record.

Personal Equipment and Valuables: I understand that CHI Health Facilities maintain an area for safekeeping of money and valuables. I understand that, except for such money and valuables which I deposit with CHI Health for safekeeping, CHI Health shall not be liable for the loss or damage of my personal property. I accept full responsibility for all property kept in my possession. I also understand that I must inform the admissions clerk or a nurse if I bring any electrical equipment to the CHI Health Facility (e.g. ventilators; BIPAP machine, CPAP machine) and adhere to CHI Health policies regarding its use. I assume full responsibility for such electrical equipment and for any injury caused by the use of the electrical equipment brought from home.

Patient Rights: I, the undersigned, have received a separate document informing me of my rights and responsibilities as a patient.
For all patients:
Acknowledgement of receipt of notice of privacy practices.
Please initial: ______ I acknowledge receipt of CHI Health's Notice of Privacy Practices.

For Hospital Patients Only:
Acknowledgement of receipt of patient rights and responsibilities information.
Please initial: _______ I acknowledge that I was provided with information about my patient rights and responsibilities.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duly authorized by or on behalf of the parent to execute the above and accept its terms.

Patient's Signature / Parent if Minor / Power of Attorney / Guardian	Date	Time ☐ a.m. ☐ p.m.
Patient Representative's Signature	Relationship to Patient	
Witness to Signatures	Date	Time ☐ a.m. ☐ p.m.
Patient Unable to Sign Consent Because	Name and/or ID of Interpreter, if used / applicable	