

Name:
DOB:
MRN:
FIN:

General Consent & Authorization

45 CFR PARTS 160-164; NH RSA 151, et seq; CAH §483.563; §483.10; §485.638

1. **Consent to Medical, Nursing and Surgical Procedures.** I consent to and authorize Littleton Regional Healthcare (LRH), its physicians, licensed independent practitioners, employees, students and other individuals involved in my care to administer such diagnostic procedures or treatment, or both, as may be ordered by the health care provider(s) caring for me at LRH to evaluate and treat my injury or illness. This consent applies to procedures or treatment provided in the emergency department, on an outpatient or inpatient basis, or in the skilled nursing area, and includes general duty nursing, surgical procedures, laboratory and other diagnostic procedures, x-ray examinations, anesthesia and other treatment(s) under the general and specific instructions of the physician(s) or other licensed independent practitioners supervising or providing my care at LRH. I acknowledge that I may be required to sign additional consent forms for certain specific medical treatments or procedures. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantee or assurance has been made to me as to the effect, result, or outcome of any examination or treatment I may receive at LRH.

2. **Relationship Between Facilities and Physicians.** I acknowledge that medical and surgical services at LRH are provided by LRH employees and agents, as well as by physicians on its Medical Staff and other health care providers, many of whom are not employees of LRH but are licensed independent practitioners who have been granted the privilege of using LRH facilities for the care of their patients. I understand that LRH affiliates with teaching institutions and, at times, my care may be provided by medical, nursing, or other health care personnel in training, to which I consent. I also consent to the presence of medical, nursing, and other health care personnel who may not be directly involved in my care, but who serve in educational or training functions. I understand that my attending physician (or his or her designee) will be responsible for my care at all times while I am a patient at LRH.

3. **Release of Information.** I acknowledge that it is the policy of LRH that patient health information is confidential and shall not be disclosed unless permitted or required by law or I have specifically authorized the disclosure in writing. I authorize LRH to release my health information: (i) to physicians and other health care practitioners on the LRH Medical Staff who are involved in my health care now and in the future; and (ii) to other health care providers, entities and institutions for the purpose of my continued care and treatment, including referrals. I also authorize LRH to release my health information to my insurance company, HMO, or other third-party payors, as necessary to bill and receive payment for my care. I recognize that information released for the purposes described in this paragraph may include sensitive information such as alcohol/drug abuse treatment, mental health and HIV/AIDS information, and I authorize the release of all such information as necessary. I understand that my consent for release of my health information may be revoked in writing at any time except to the extent that LRH or my health care provider(s) have already taken action in reliance on my consent.

4. **Facility Directory (Inpatients & Emergency Room Only).** I acknowledge that LRH may include certain limited personal information about me in the hospital directory while I am a patient at LRH. This information may include my name, location in the hospital (room number), my general condition (fair, stable, etc.) and my religious affiliation. I understand that the directory information, except for my religious affiliation, may be released to people who ask for me by name, so that my family and friends can visit me at LRH and be made aware of how I am doing. Directory information including my religious affiliation may be released to clergy so they can visit me at LRH. I understand that I have the right to opt out of including my name in the facility directory for anyone except my health care providers at LRH. If I do opt out, I understand that LRH will be unable to notify others of my presence at LRH, including for flower deliveries, phone calls, and visits from family members, clergy, and friends. I understand that, as permitted by law, LRH may include my personal information from the hospital directory in the event I am incapacitated or undergoing emergency medical treatment, but such use of my personal information shall be consistent with my prior expressed wishes, if any.

[Please initial your choice regarding inclusion in the hospital directory:]

_____ Yes, LRH **may** list my name and other limited personal information in the facility directory, as described above.

_____ No, LRH **may not** list my name and other limited personal information in the facility directory, as described above.

5. **Notice of Privacy Practices Acknowledgement.** I understand that LRH's "Notice of Privacy Practices," as required by federal law provides detailed information about how LRH may use and disclose my protected health information, and also describes my rights concerning my protected health information. I understand that I have a right to receive a paper copy of the Notice of Privacy Practices or that I may review an electronic copy at LRH's website, www.littletonhealthcare.org. I acknowledge that I have been offered a paper copy of LRH's Notice of Privacy Practices.

6. **Patient Rights and Responsibilities Acknowledgement (Inpatients & Emergency Room Only).** I understand that LRH's "Patient Rights and Responsibilities" brochure contains valuable information about my rights and responsibilities as a patient at LRH, including a description of LRH's procedures for resolution of any complaints.

I acknowledge that I have received a copy of LRH's "Patient Rights and Responsibilities" brochure. _____

Littleton Regional Healthcare
600 St. Johnsbury Road
Littleton, NH 03561

Patient Identification
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7. **Financial Agreements.** I understand that I am obligated to pay LRH's usual and customary charges for all services received by me at LRH. If my account is referred to a collection agency or attorney, I agree to pay reasonable attorney's fees and collection expenses. I understand that I may be asked to sign a separate financial agreement for all amounts not covered under an insurance policy, health care service plan, managed care program or by any third-party payor not a party to this agreement.

8. **Uninsured Patients.** If I do not have health insurance, I may be able to use LRH's uninsured discount program. My bill for all needed medical services I receive at LRH will show the current adjusted rate. This rate can change each year (per the LRH Financial Assistance Policy).

By signing below, I declare that I do not currently have medical insurance which could pay all or part of my hospital bill. I understand that if I am found to have medical insurance at the time I received hospital services, the automatic discount will be removed from my bill.

_____	_____ / ____ / ____
Print Name	Signature Date

9. **Assignment of Benefits.** I authorize payment directly to LRH of any insurance or other third-party benefits (otherwise payable to me) to which I am entitled for my treatment at LRH. I understand that I am responsible for providing LRH with information necessary to allow LRH to bill my insurance. I understand I am financially responsible for payment of any charges not paid by insurance or other third party including if I have no insurance or coverage is denied. I further understand LRH does not accept responsibility for collecting my insurance claim or negotiating a settlement on a disputed claim, and that I am responsible for the timely payment of my account(s).

10. **Health Care Service Plans.** I acknowledge that, if I am a member of a health care service plan or covered under a managed care plan, it is my responsibility to provide to LRH the name of the plan, my primary care physician's name and telephone number, to present confirmation of eligibility and to obtain authorization for services from the plan. Failure by me to provide this information or obtain such authorization may result in services not being covered under my plan and LRH may bill me for such services, as described above.

11. **Medicare/Medicaid Payment.** I certify that the information given by me in applying for, or assigning, payment under Medicare or Medicaid is correct. I request payment of authorized Medicare or Medicaid benefits be paid to LRH on my behalf for services furnished to me, including physician services. I authorize LRH to release any information about me that is necessary to act on this request for payment.

12. **Patient Valuables.** I understand that LRH has a safe for keeping money and valuables for patients during their stay, and that LRH is not liable for damage to or loss or theft of any money, documents, or any other personal property of patients unless that money or personal property is deposited with LRH for safekeeping, provided that I understand that LRH's liability for such deposited money or personal property will not exceed the lesser of the actual documented value of such personal property or five hundred dollars (\$500.00), unless LRH has provided a written receipt for a greater stated value of the money or personal property.

13. **Patient Satisfaction Surveys.** I agree that, in an effort to improve quality of care and patient satisfaction, LRH may contact me after discharge for the purpose of requesting my participation in patient satisfaction surveys or to inform me of available services at LRH. I understand that LRH uses an independent agency to administer, collect, and compile results of these surveys, and that I am not required to respond to such requests.

I have read the information on this form (or have had it read to me). I have had an opportunity to ask questions and have had them answered to my satisfaction. I understand and agree to all of the terms above unless otherwise noted. I certify that I am the patient or the patient's legal representative with authority to sign this document on the patient's behalf.

Signature of Patient or Authorized Representative: _____

Print Name: _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney) _____

Date: ____/____/____ Time: _____

Witness Signature: _____ Date: ____/____/____

Patient is unable to sign because: Minor Other _____

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Littleton, NH 03561