CHESAPEAKE REGIONAL
MEDICAL CENTER

2TREAT

CONSENT FOR TREATMENT
RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY

The person named below (hereinafter called "Patient") has been received for services including, but not limited to, outpatient diagnostic testing, surgery, emergency/urgent treatment, and/or admitted, or is the legal parent of a newborn delivered in the facility, The Guarantor listed for Patient has been accepted as the guarantor of payment by Chesapeake Regional Medical Center (hereinafter called "Hospital"). During the patient's treatment in this Hospital it is possible that the status of the patient may be changed to observation. An observation placement is not considered to be an admission, but an outpatient visit. If such a change occurs, it is the policy of this hospital to notify the patient within 24 hours of the change, and provide information to the patient for follow up with their insurance company for further clarification of financial responsibility.

AUTHORIZATION FOR TREATMENT: Patient consents to the following: That the attending physician, the clinical and technical employees of the hospital, any consulting physicians or any assistants, whom they may call to their aid, may administer any treatment deemed advisable in the care and treatment of the Patient. Patient also consents to all procedures that, whether for diagnosis or treatment prior to or during the procedure may be deemed advisable in their care and treatment. Patient further understands that no guarantee of assurance has been made as to the results that may be obtained. Further information concerning the delivery of care and rights of the patient can be found in the CRMC Rights Document, found under separate cover of this consent.

CONSENT FOR PHOTOGRAPH: The Patient/Representative gives permission to the hospital to photograph the patient. The photograph will be used solely for clinical documentation and will be placed in the Patient's medical record. The Patient/Representative has the right to request the photo session end at any time and has the right to withdraw the consent. The photograph will be stored in the Patient's medical record and will be destroyed when no longer needed. Chesapeake Regional Medical Center will not release the photograph without the Patient/Representative's authorization.

TERMS FOR FINANCIAL AGREEMENT: ***The patient/guarantor agrees to pay all charges made by the hospital or other service providers for services rendered for this date. Any portion of the bill not covered by insurance or other benefit is due in full at time of service or discharge, unless prior arrangements are made. Payer reimbursement is accepted as payment based on contracted rates with the patient's/guarantor's plan as may participate with the Hospital, and remaining balances adjusted according to the terms of the contractual agreement.***

INSURANCE AGREEMENT: Patient and/or Guarantor understand that insurance is a contract between the subscriber and the insurance company and that the Hospital will bill the insurance carrier as a courtesy to the patient or as agreed upon in contractual arrangement with the insurance company or as required by governmental regulations. All required authorizations, pre-certifications, and/or referral forms are the responsibility of the Patient. If required procedures are not followed to the satisfaction of the insurance company, payment for certain services will become the responsibility of the Patient. The Patient also understands that all physicians furnishing services to the Patient, including radiologists, anesthesiologists, and the like, are independent contractors and are neither employees nor agents of the Hospital. A separate billing will be rendered for services provided by them. The undersigned patient, spouse, and/or responsible party, agree that they will pay any physician's charges in accordance with regular terms and charges.

ASSIGNMENT OF BENEFITS: The Patient and/or the insured requests that payment of any existing insurance benefits are made on their behalf to all providers of service during this encounter. Patient understands that it is necessary for the hospital to release certain medical information in order to receive payment of its debt from third party insurers or governmental "providers". Accordingly, patient will not in any way interfere with the hospital's attempts to collect insurance or governmental proceeds due and will furthermore not make any attempt to revoke this authorization.

Any unpaid balance, whether covered by insurance or other benefit, will be subject to having the hospital proceed against the patient, spouse, or responsible party without making a request for payment or taking any action, or proceeding against the other. *EACH OF THE UNDERSIGNED WAIVES THE BENEFITS OF THE HOMESTEAD EXEMPTION AS TO THIS DEBT. EACH FURTHER AGREES TO PAY ALL COSTS OF COLLECTION, INCLUDING AN ATTORNEY'S FEE OR COLLECTION FEE OF THIRTY (30) PERCENT OF THE UNPAID BILL AT THE TIME OF PLACEMENT WITH SUCH ATTORNEY OR COLLECTION AGENCY*. Any overpayments that would otherwise be eligible for refund to the Guarantor will be applied to outstanding balances on other accounts that are the responsibility of the same Guarantor. My obligation to pay is cumulative and in addition to all other remedies of CRMC and its Medical Staff physicians from a Consumer Reporting Agency as regulated by the Fair Credit Reporting Act and I expressly authorize the use of automatic dialing system and pre-recorded voice form contact by telephone, cellular telephone paging services or electronic mail.

IMPORTANT - THIS CONSENT IS CONTINUED ON THE REVERSE SIDE
READ THE SECOND PAGE OF THIS CONSENT PRIOR TO SIGNING

Patient Label

CONTINUED FROM FRONT SIDE
READ BOTH SIDES PRIOR TO SIGNING

2TREAT

ACKNOWLEDGMENT FOR HIV/HBV/HCV TESTING: The Code of Virginia (32. 1-45.1) authorizes health care providers to test patients for HIV (human immunodeficiency virus), hepatitis B virus, and hepatitis C virus when a health care provider is exposed to the blood or body fluids of a patient in a manner which may transmit the viruses. In the event of such exposure, the Patient will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who has been exposed. The Patient will be offered the opportunity for face-to-face disclosure of the test results and counseling if conscious. In the event, the Patient is unconscious, the Legal Representative of the Patient or Surrogate will be deemed to have consented to the testing. If the patient remains unconscious, the test results may be released to the legal representative or surrogate only in the event the surrogate is the spouse.

VALUABLES: It is understood and agreed that the hospital will maintain facilities for the safe keeping of money, valuables, and other personal property small enough to fit into the Hospital safe. The Hospital strongly encourages the patient not to bring valuables or personal property with them and the Hospital shall not be liable for the loss of, or damage to: valuables, money, personal possessions, dentures, etc., not deposited with Patient Access Services for safekeeping.

NO SMOKING POLICY: It is understood that CRMC is a smoke-free environment. There is no smoking anywhere on the CRMC campus. If patient leaves the facility or campus at any time, the patient understands they will not be monitored by the nursing staff; the physician will be informed; complications may occur off-site; and proper medical aid will be unavailable. The patient releases the hospital from damages or injuries sustained while smoking off-campus.

ADVANCED DIRECTIVES: The Patient certifies that they received information regarding Advance Directives. Upon request, additional information may be provided to the Patient by their health care provider or physician. A caregiver is available to assist any patient wishing to draft an advance directive.

RELEASE OF INFORMATION: Patient grants permission to the Hospital, agent, or treating physicians to release psychiatric, substance abuse, AIDS/HIV-related, or medical/surgical information to any insurance company having insurance in force on the Patient, as may be required or requested from the respective provider's files. The Patient authorizes the Hospital to release information from their medical records to the Social Security Administration, its intermediaries, or carriers, and to any utilization and/or quality review organization affiliated with their insurers for use in utilization management, any information needed for this, or a related Medicare or Medicaid claim. The Patient further authorizes the Hospital to provide from its own records pertinent medical information to other health related agencies and facilities involved in their continuing care after hospital discharge for up to ninety days. Patient also agrees that their medical records may be reviewed as part of an internal quality assurance process, including our agents.

Chesapeake Regional Medical Center is required by law to maintain the privacy of your health information (Protected Health Information or PHI).

The Patient/Guarantor signature on the reverse side of this consent form certifies that the Patient/Guarantor has received the pamphlet "Notice of Privacy Practices" describing how medical information about the Patient may be used and disclosed in accordance with federal regulations. Patient certifies that they have had an opportunity to review the "Notice of Privacy Practices" and offered additional information if requested.

FOR FURTHER INFORMATION REGARDING YOUR PROTECTED HEALTH INFORMATION

If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office of Civil Rights of the U.S. Department of Health and Human Services for which, upon request, the address can be provided to you by the Director of Health Information Systems Department of Chesapeake Regional Medical Center.

You may contact the Health Information Services / Privacy Office at:
Health Information Services / Privacy Office, Chesapeake Regional Medical Center
736 Battlefield Boulevard, North, Chesapeake, VA 23320
Telephone Number (757) 312-6114

DECLARATION OF UNDERSTANDING: The signature below certifies that I have read, or have had read to me, this entire form, including the reverse side of this consent which contains additional information about what health information can legally be released by Chesapeake Regional Medical Center and I certify that I understand its contents and been given the opportunity to request further information. This printed contract is intended as the complete agreement between the Patient/Guarantor and the Hospital, and Chesapeake Regional Medical Center/Chesapeake Health shall not be bound by any verbal agreement or modification of the terms of such printed contract. Any modification or amendment to this agreement shall be in writing signed by both parties in the presence of witnesses.

_____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE

_____ _____ Patient unable to sign _____
GUARANTOR DATE

By law The Hospital may release the following patient directory information to anyone who asks: The fact that you are a patient at the Hospital or in the Emergency Department and a one-word statement about your condition (Good, Fair, Serious, Critical) If you do not want this information released, you can request that it not be given out. If you request this, the staff cannot give any information about you to anyone, including your family, friends or clergy. Staff cannot tell people that you are here or put through any phone calls to you.

The hospital may release patient directory information about me. ❑ Yes ❑ No Patient Initials* _____

Patient Label