GRIFFIN HEALTH

130 Division Street, Derby, CT 06418

ADM.ACK

Patient Acknowledgement Form

Consent to Treat and Contact

Purpose: Permits Griffin Hospital and independent healthcare providers affiliated with Griffin Hospital to provide patient care and post-acute care.

Consent to treatment and services: I agree ("consent') to medical treatment or hospital services considered necessary. Those services may be provided to me as an inpatient (admitted to the hospital), an outpatient (not admitted to the hospital), an observation patient, or an Emergency Services patient. Those services include, but are not limited to, diagnostic imaging examinations, laboratory procedures (including blood work), administration of anesthesia, and post-acute care programs to manage chronic diseases. If appropriate, I also consent to examination of my specimens, imaging studies, and other tests or studies by healthcare personnel or entities other than Griffin Hospital. I understand that this consent, or any part of it, may be revoked by me at any time but that the hospital is entitled to rely on the consent I have given until it has been revoked. I understand that I may revoke my consent to participate in any post-acute programs by utilizing the opt-out method that will be provided to me in connection with these programs.

Healthcare Providers and Billing: I have been informed that some healthcare providers who care for me at Griffin Hospital, or its associated facilities, are independent practitioners who are not employees or agents of the hospital. They include, but are not limited to, physicians or others who provide anesthesiology, cardiology, emergency medicine, G.I. procedures, pathology, radiation oncology, or radiology services. Because they are independent of the hospital, I understand they may bill me separately from the hospital's bill.

Medical training: I understand that among those who attend patients at Griffin Hospital are medical, nursing, and other healthcare personnel in training who may be present or participate in my care as a part of their education. Photography and/or closed circuit television monitoring may also be used for educational purposes unless I expressly direct otherwise.

Disposal of bodily tissue: I consent to the disposal of my tissues or body parts that may be surgically removed in accordance with Griffin Hospital's usual and customary practices.

Research: I permit non-identifiable, personal information in my health care record, including psychiatric/psychological, drug, alcohol, or other substance abuse, AIDS or HIV-related, or sexually transmitted diseases to be used confidentially for research purposes.

Advance Directive Status and Patients' Rights Information

Purpose: Addresses documents expressing patients' advance decisions concerning medical treatment they wish to be applied (or not applied) in the event of their physical or mental inability to communicate those wishes.

Different types of advance directives include: Living will, appointment of health care representative and/or designation of individual to be appointed as conservator, conservator of the person (appointed by the court), and anatomical gift.

When asked whether the patient has formulated an advance directive, the undersigned has responded:

- ☐ **Yes**, and a copy is included in the patient record. [Type(s) of advance directive(s) shown above.]
- ☐ **Yes**, but a copy has not been provided. The patient and/or the patient' s representative has been notified that it is the responsibility of the patient to provide the hospital and the attending physician with a copy of the Advance Directive(s).
- ☐ **No**, and the patient is not interested in more information.
- ☐ **No**, but I have received Griffin Hospital's information pamphlet about Advance Directives.

Comments:

If Patient/Responsible person unable to sign list reason: _____

Responsible person's Relationship to Patient: _____

_____

Patient Signature or Responsible person **Date/Time**

_____

Interviewer's signature **Date/Time**

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Patient Acknowledgement Form

Receipt of Notice of Privacy Practices and Patients' Rights Information

Purpose: Confirms that Griffin Hospital has complied with its obligation to provide patients with an explanation of its privacy practices under the Health Insurance Portability and Accountability Act (HIPAA) and that the information on the rights of patients was provided.

I have received Griffin Hospital's Notice of Privacy Practices and Patients' Rights information.

Required - If not initialed, state reason: _____

Follow-up - Initials obtained on _____ by: _____

Release of Information for Insurance, Assignment of Benefits, and Appeal Process

Purpose: Permits Griffin Hospital to release patient information for post-acute care and obtaining payment for care provided.

Release of confidential information: I understand that my health care information is confidential and is protected from disclosure by law, but that it may be used for treatment, payment for services provided, and healthcare operations. I consent for my medical information to be released to entities that provide post-acute care and services.

Release to insurer: I understand that Griffin Hospital and/or any physician, entity, or organization providing medical services to me may release information to my insurance carrier(s) to substantiate payment for hospitalization and medical care, or employers (and/or their insurance carriers) in Workers' Compensation matters. Such persons or entities are permitted to examine and obtain necessary information from my medical records in accordance with applicable law related to patients' confidential health information and the Medical Records policies of Griffin Hospital.

Assignment of benefits: I assign to Griffin Hospital and/or any physician, entity, or organization providing medical services to me any and all benefits, including payment, to which I may be entitled. Payments include those from any government agency, insurance carrier, or others financially responsible for the hospitalization and medical care rendered to me or my dependent.

Appeal: I agree that Griffin Hospital may appeal any disallowance of payment by my insurance company for care received.

Medicare Insurance (*Applicable only if your insurance is provided through Medicare*)

Purpose: Permits the hospital to receive payment from Medicare.

Certification of accuracy: I certify that the information I have provided for the purpose of applying for payment under title XVIII of the Social Security Act is accurate. Authorization to release information: I understand that any holder of my medical or other information regarding my treatment may release to the Social Security Administration and/or the Centers for Medicare & Medicaid Services, or its intermediaries or carriers, any necessary information needed in relation to a Medicare claim.

Request for payment: In relation to a Medicare claim, I request that payment of authorized benefits be made on my behalf. Assignment of Medicare benefits: I assign the Medicare benefits payable for physician services to the physician, entity, or organization furnishing the services or authorize such physician, entity, or organization to submit a claim to Medicare on my behalf.

Financial Agreement/Guarantee/Collection

Purpose: The patient accepts responsibility for payment of co-payments and services not covered by insurance or other payor.

For services rendered or to be rendered, 1, for myself and my representatives, promise to pay to Griffin Hospital and/or any physician, entity, or organization providing medical services to me, the full and entire amount of any and all bills not paid by any insurance plan, private or governmental, or combination of plans, including any required deductible and/or co-pay amounts. I understand that all such bills are due and payable upon request. Payment may be required at any time from the undersigned Guarantor and the hospital's failure to demand payment shall not be a prerequisite to the guarantor's immediate responsibility for payment. In the event
this account is referred for collection, I/we understand and agree to pay in addition to the above, all costs, fees, court and attorneys' fees.

Guaranty of payment: I agree that if all or part of my hospital bill is not covered by any medical insurance plan, or Worker's Compensation insurance, payment of the balance shall be due immediately on notice.

Personal Valuables

Purpose: Identifies methods to provide for the safety of personal valuables.

I understand that Griffin Hospital maintains a safe for the safekeeping of patients' money and valuables. I agree that the hospital is not responsible for the loss of, or damage to, my personal valuables, such as money, jewelry, documents, furs, or other articles of value or small size, including but not limited to dental work or dental prosthetics (dentures), eye glasses, credit cards, hearing aids, telephones, portable electronics, etc., unless placed in the safe. I have been advised that my personal valuables should be given to an accompanying friend or family member to be returned home for safekeeping. Except for items that have been placed in the hospital safe for safekeeping and for which a receipt has been issued, I hereby waive any and all rights to compensation for any such losses and release Griffin Hospital from any and all liability for any loss or damage to my personal valuables no matter how that may occur.

I/We agree and accept the initialed terms of this document.

If Patient/Responsible Person is unable to sign list reason: _____

Responsible Person (Guarantor) Relationship to Patient: _____

Comments:

Signature of Patient or Responsible Person (Guarantor) Date/Time

Interviewer's Signature Date/Time