St. Anthony Community Hospital
Westchester Medical Center Health Network

GENERAL CONSENT FOR TREATMENT

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of Westchester Medical Center (WMC), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood as well as access to my medication history data. I understand and authorize the administration of pharmaceutical agents and medications by anyone of several techniques including peripheral intravenous access (inserted into a vein in an arm or leg) and peripheral insertion of a venous catheter that then enters the central circulation (PICC line). I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at WMC. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct WMC and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors and employers of self-funded plans.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND FINANCIAL ASSISTANCE PROGRAM: I hereby assign to WMC any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by WMC, whether such services are considered in-or out-of-network with respect to any third party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to WMC, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to WMC for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. I understand I will receive a separate bill from my attending physician, emergency department physician, radiologist, anesthesiologist and other consultants. (However, if treatment has been given in accordance with New York State's No-Fault Law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee Schedules.) As part of WMC's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. WMC has a Financial Assistance Program for patients who financially qualify. Please ask for more details.

CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND/OR EMAILS: I hereby consent to WMC to contact me by voice call, text message and email at the Account contact telephone number (s) and Email address (es) reflected on my account. I understand that, by giving this consent WMC may contact me about my medical care, or my account, such as appointment, the results of any tests or procedures, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE:
By signing below, I acknowledge receipt of the important information about paying for your care.

TELEPSYCHIATRY: I have been given basic information regarding the use of Telepsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Telepsychiatry services, in which case evaluations will not be withheld, but will be conducted in-person by appropriate clinicians. I also understand that upon my refusal of such services I will be apprised of the alternatives to Telepsychiatry services, including any delays in service, need to travel, or risks associated with not having the services provided by Telepsychiatry. Furthermore, I am made aware that each Telepsychiatry session shall not be recorded without my consent.

__________ **I do not want to participate in Telepsychiatry**

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RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the hospital and understand and agree that WMC shall not be liable forloss or damage to any personal property. Please initial in the space provided to the left:

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IF ADMITTED AS AN INPATIENT: I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare", information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient) with information about how I can exercise the right explained in these materials. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information. In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days.

__________ **I do not authorize WMC to utilize my Lifetime Reserve Medicare days.**

DESIGNATED CAREGIVER: I authorize WMC to share my PHI with my designated caregiver (s). Please initial in the space provided to the left.

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If you are signing this Consent as the patient's Authorized Representative, put an "X" in the box that shows your legal relationship to the patient:

☐ pediatric patient's parent, guardian, custodian, or foster parent
☐ patient's spouse or domestic partner or surrogate
☐ patient's legal guardian
☐ patient's healthcare proxy

☐ other legal relationship: ____

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: ______________________________________
Patient

Signed: ______________________________________
Legal authorized Representative

Witness: ______________________________________

Date/Time ______________________________________

TELEPHONE CONSENT IS GRANTED BY (if required)

Signed: ______________________________________
Name of legal representative and relationship to patient.

Signed: ______________________________________
Signature of caller.

Witness: ______________________________________

Date/Time ______________________________________

OFFICE USE ONLY:

☐ Patient is unable to provide consent due to condition
☐ Patient refused to sign

Hospital Staff Person's Name ______________________________ Date/Time: ______________