AtlantiCare
REGIONAL MEDICAL CENTER

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GENERAL CONSENT FOR TREATMENT

Patient Label

Patient Name: ____

1. **Consent for Treatment.** I acknowledge that I (or the patient listed on the top of this form is) suffer(s) from a condition that requires medical treatment and/or hospital care. By presenting for treatment at AtlantiCare Regional Medical Center (hereinafter "ARMC"), I voluntarily consent to medical treatment or hospital care, including emergency treatment, routine diagnostic procedures, x-rays and other such medical care and treatment as the Physician or Licensed Allied Health Professional, (defined as an Advance Practice Nurse, Physician Assistant, Nurse Midwife, or Certified Registered Nurse Anesthetist who is operating within the scope of his/her practice and as authorized pursuant to ARMC's Medical Staff Bylaws to collaborate with or practice under the supervision and direction of a Physician, hereinafter referred to as "Licensed AHP") considers necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my care, treatment or examination at ARMC. Patients at AtlantiCare Regional Medical Center will be treated regardless of their race, color, age, national origin, disability, religion, ability to pay or method of payment.
2. **Informed Consent.** I understand and acknowledge that:
   A. It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive procedure shall be performed on me unless or until I have had an opportunity to discuss my medical condition, the substantial risks and benefits of treatment my options, as well as alternate treatment options, with my Physician or Licensed Allied Health Professional (within his scope of practice) to my satisfaction;
   B. I have the right to consent to, refuse to consent to, any proposed treatment, procedure or therapeutic course of action;
   C. I will not be involved in any research or experimental procedures or treatment without my full knowledge and consent.
3. **Consent for Treatment of Newborn Infant.** If I am admitted for the delivery of a child(ren), I hereby authorize admission, emergency treatment, routine diagnostic procedures and such other medical treatment of newborn infant(s) who is/are delivered by me during this hospitalization.
4. **Independent Contractors.** I acknowledge that not all Health Care Providers are ARMC or AtlantiCare agents, servants or employees. I understand that many physicians and licensed AHP's who participate in my care while I am at ARMC are INDEPENDENT PROVIDERS AND ARE NOT EMPLOYED BY NOR AGENTS OF ARMC or ATLANTICARE. These Independent Providers are members of ARMC's Medical Staff who have been granted the privilege of using its facility for the care and treatment of their patients. Likewise, ARMC may contract with independent physicians or physician groups of various specialties to provide services at ARMC for example, emergency, radiology, and pathology ("Independent Contractors"). INDEPENDENT CONTRACTORS ARE NOT EMPLOYEES OR AGENTS of ARMC or AtlantiCare. Neither ARMC nor AtlantiCare has any direct or indirect liability for any acts or omissions of these physicians, licensed AHPs or independent physician groups, even if they are wearing an ARMC or AtlantiCare identification badge.
5. **Against Medical Advice.** If, after consenting to treatment, I leave ARMC without the approval of my treating Physician or Licensed AHP, I hereby relieve ARMC and said Physician or Licensed AHP of all responsibility for my action.
6. **Hospital Patient Bill of Rights.** I acknowledge that I have been given a copy of ARMC's Patient Bill of Rights. I acknowledge that any questions about such rights have been answered to my satisfaction.
7. **Release of Responsibility for Valuables/Belongings Retained by Patient.** I understand that ARMC maintains a safe for the safekeeping of money and other valuables. I have been informed and understand that ARMC is NOT responsible in the event of loss of any wearing apparel or personal property, including cash, dentures, hearing aids, eyeglasses, jewelry or other valuables/belongings that I retain while at ARMC and that have not been taken into the care, custody and control of ARMC.
8. **Acknowledgement of Privacy Practice.** I understand and have been provided with ARMC's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. ARMC reserves the right to make changes to the Notice of Privacy Practices. Revised copies are available to all patients in registration areas. By signing this form, I acknowledge that I have been afforded an opportunity to consider ARMC's Notice of Privacy Practice prior to signing this consent and making healthcare decisions.
9. **Medical Records Information.** ARMC maintains patient medical records in paper, microfilm and/or electronic media that may be accessible to any physician or health care provider participating in my current or future care. I understand that these records will contain information about my diagnosis and treatment and may or may not contain information pertaining to psychiatric care, alcohol or drug abuse, venereal disease, genetic information and HIV counseling or testing.

   In connection with the medical care provided to me at ARMC, except as otherwise prohibited by law, by my signature below, I hereby grant permission for ARMC and my treating Physician or Licensed AHP, to release medical records information about me to my health care insurer (including Medicare), my current health care providers and/or other potential health care providers, and to provide a discharge summary of my treatment at ARMC to the Primary Care Provider I identify during patient registration. This information may include HIV, psychiatric, drug/alcohol venereal disease, genetic information and/or infectious diseases information. Medical records are disclosed according to applicable

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New Jersey State laws, Federal laws 42 and 45 C.F.R and the provisions of this consent. In accordance with the NJ Care Act, I hereby designate a Caregiver who will provide after-care assistance to me at my home upon discharge from ARMC. I further give my consent to ARMC to release medical information to my designated caregiver following the hospital's established procedures for releasing personal health information and in compliance with all State and federal laws, including the federal "Health Insurance Portability and Accountability Act of 1996, and related regulations. I understand that I have the right to change my designated caregiver at any time.

10. **Insurance Assignment.** I hereby assign to ARMC and Physician and/or Licensed AHP participating in my care any and all rights and benefits to which I may be entitled arising out of any health care or liability insurance. I hold ARMC, my Physician and/or Licensed AHPs harmless for any reduction in health care benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require notification, pre-certification, prior or retrospective authorization or utilization review of the medical services I have received. I agree that I am financially responsible for deductibles, co-insurance and uncovered services that are not covered by my insurance policy.
11. **Financial Responsibility.** I agree to pay ARMC the full and final amounts of any and all bills for services rendered to me (or the named patient) that are not covered by my insurance. I authorize ARMC to utilize the appeals process with my insurance carrier on my behalf for any denied services. I recognize that ARMC or its designee has no obligation to pursue such an appeal. I authorize that ARMC or its designee can contact me regarding my financial responsibility at any telephone number associated with my account, which includes a wireless telephone number which could result in charges to me. I authorize to receive contact from ARMC or its designee on my financial responsibility in various methods such as but not limited to text message, email, or pre-recorded voice message.
12. **Medicare.** I certify that the information given by me in applying for payment under Titles XVIII and XVIX of the Social Security Act is correct. As applicable, I certify that I have reviewed the Important Message from Medicare.
13. **Photographs.** I agree to have my facial photo representation taken upon registration to be used for patient identification and to be kept in my medical records for identification purposes. I further consent to the taking and use of photographs in the course of the operation for medical record documentation and teaching purposes. I understand that camera surveillance may be used throughout ARMC, as required by the New Jersey Department of Health and Senior Services, for my safety.
14. **Specimens.** I authorize ARMC to retain, preserve and use for teaching purposes, or dispose of at their convenience, any specimen or tissues taken from my body during my treatment or hospitalization.
15. **Appealing Charges.** I am aware that after receiving services I can question or appeal any charges to me for services. I can contact the AtlantiCare Business Office Customer Service at 609-272-2500 for further assistance in the process.
16. **Communication.** By providing my telephone number, I consent to health care related communicates (e.g., appointment reminders), patient satisfaction surveys and similar purposes, as well as to receive contact from ARMC or its designee on my financial responsibility in various methods such as but not limited to text message, email, or pre-recorded voice message.

I HAVE READ THIS FORM OR HAD IT FULLY EXPLAINED TO ME. I AM SATISFIED THAT I UNDERSTAND ITS CONTENTS AND SIGNIFICANCE. I AM SIGNING THIS CONSENT VOLUNTARILY.

________ **I acknowledge understanding the Relationship of Physicians to Hospital and Related Billing Information.**
INITIAL

________ **I acknowledge receipt of the Notice of Privacy Practice.**
INITIAL

________ **I acknowledge that I have been given a copy of the ARMC Patient Rights and Notice of Visitation Rights. I fully understand the information provided to me (or my representative, as applicable)**
INITIAL

Signature of patient or patient's representative: ______________________ Date: __________ Time: __________

Representative's relationship to patient: ______________________

Witness to signature: ______________________ Date: __________ Time: __________

Patient is unable to consent because: ______________________ Date: __________ Time: __________

Second Witness to signature if patient is unable to consent: ______________________ Date: __________ Time: __________

Caregiver Name: ______________________