WakeMed Consent/Authorization

Authorization For Diagnosis and Treatment

I, having a condition requiring health care, hereby consent to the provision of such care, which may include routine diagnostic procedures and such treatment as the attending physician(s) or others of the hospital's medical staff consider necessary. I understand that WakeMed is a teaching institution, and I agree that students training to be physicians, nurses, allied health professionals and/or students training in other health related fields may assist in providing my care and that my medical records may be used for purposes of research, education and patient care. I understand that some physicians provide their services as independent contractors to this hospital, and that the hospital is not liable for their acts or omissions.

Medical/Medicaid Patient's Certification: Authorization To Release Information And Payment Request

I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records by WakeMed required to act on this request. I request that payments of authorized benefits be made on my behalf. This request expires two years from today. I understand I can revoke this authorization at any time prior to that if WakeMed is notified in writing.

Assignment of Insurance Benefits

I hereby authorize payment of hospital benefits, including major medical, directly to WakeMed. I also authorize payment of surgical and/or medical benefits, including major medical, directly to all treating and consulting physician(s) (including WakeMed Faculty Physicians) and vendors, including but not limited to the following independent contractors: Raleigh Pathology Lab Assoc., PA, Critical Health Systems of North Carolina, Wake Radiology Consultants, PA, Wake Emergency Physicians, PA, and other contracted professionals. I understand that I am financially responsible to the hospital and physician(s) providing treatment or consultation, even if such treatment is not covered by insurance.

Authorization For Payment

I do hereby expressly agree to pay and guarantee payment in full of any and all charges for hospital services provided. I understand that my bill will be sent to the address on file unless I complete a request for my bill to be sent to an alternate address.

Authorization For Release of Medical Information

The hospital and licensed physicians providing my care are authorized to release medical information for purposes of treatment, payment and health care operations, including releases to other groups identified under the Assignment of Insurance Benefits section, to emergency transport services, and to entities requiring releases for:

1) processing applications for financial coverage rendered during the admission;
2) external review agencies regarding eligibility for continued hospitalization insurance, payment of benefits, or billing compliance;
3) the acquisition and provision of appropriate care after discharge (including telephone follow-up calls/messages to me/my representative);
4) audits/inspections by agencies of the North Carolina Department of Health and Human Services (DHHS). I understand that I may object in writing to the inspection of my records by the N.C. DHHS and thereby prohibit such inspection.

If I am a pregnant patient of both WakeMed and Wake County Human Services or if my child is a patient of both WakeMed and Wake County Human Services, I authorize each and their physicians to share medical information regarding the acquisition and provision of appropriate care during prenatal care, admission(s) to the hospital, delivery, postpartum care, neonatal and child care and following discharge(s). I also understand and agree that if I request a copy of my record and/or my child's record from either WakeMed or Wake County Human Services that the record may include portions of the medical record from the other entity.

I understand that my name, location and general condition (fair, stable, serious, etc.) will be included in the patient log and will be released, if requested, to callers and/or visitors.

Release of Liability For Valuables

This hospital cannot assume liability for money or valuables taken to the patient's room/treatment area. Money and valuables may be deposited in the hospital safe during your stay.

I understand and agree to the above releases, authorizations and assignments of benefits:

Signature (Seal): ______________________________ Date: ____________
(Patient or legal guardian/closest available relative/authorized representative, if patient unable to sign)

Signature (Seal): ______________________________ Date: ____________
(Insured/Guarantor, if different from Guardian/Relative/authorized representative)

Consent to Diagnosis and Treatment Obtained By Telephone

Treatment / procedure: ______________________________

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Authorized Person Giving Consent: ______________________________

Telephone #: ____________

Relationship to Patient: ______________________________

Witness: ______________________________

Witness: ______________________________

Date: ____________ Time: ____________

PLATE 3/03

Acknowledgement of Receipt of the WakeMed Notice of Privacy Practices

I certify that I have received a copy of the WakeMed Notice of Privacy Practices.

Signature: ______________________________

Print name: ______________________________

Date: ______________________________

___ Signature obtained after initial registration

Staff Use Only:

- ❑ Patient unable to sign due to condition and/or level of consciousness
- ❑ Patient refused to sign after receiving Privacy Notice
- ❑ For ED use only (Privacy Notice given to minor/caretaker in absence of parent)
- ❑ For ED use only (unable to sign due to emergency transfer to another hospital)
- ❑ Other ______________________________

Completed by: ____________________ Date: ____________