COLUMBIA MEMORIAL HOSPITAL

Rapid Care

Patients Name:_____ D.O.B._____

Date:_____ Valatie Rapid Care

Permission for General Admission & Emergency Treatment

1. Permission

I hereby authorize my (patient's) admission, outpatient and emergency care to Columbia Memorial Hospital and/or its clinical or outpatient departments (the Hospital). And I authorize the Hospital physicians, dentist, and allied health professions on its staff, the members of its house staff, nursing care and to administer such routine diagnostic test and procedures. Including but not limited to pharmaceutical products and medications: the drawing of blood. As my (patient's) attending physician and the about Hospital personnel deem necessary or advisable in my (patient's) care. Attending physician and the making of photographs of me (the patient is) in connection with the medical and other services which I am (the patient is) receiving from the Hospital.

2. No Guarantee

I acknowledge that no guarantee for assurances have been made to me concerning the treatments or examinations performed upon me (the patient) in the Hospital.

3. Opportunity to Ask Questions

I confirm that I have been given an opportunity to ask any questions regarding general admission tests and procedures and that all such questions have been answered fully and satisfactorily.

4. Understanding of This Form

I confirm that I have read the form and fully understand its contents.

Patient/Relative/Guardian*:_____

Signature Print Name

Relationship if other
Than patient's signed:_____

Interpreter, if
Required:_____

Signature Print Name

Witness:_____

Signature Print Name

***The signature of the patient must be obtained unless the patient is an emancipated minor under the age of 18 or is otherwise incompetent to sign.**

Note: This document must be made part of the patient's medical record.

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Patients Name:_____D.O.B_____

Date:_____ Valatie Rapid Care

Release Of Information And Financial Responsibility

Release of Information
I, the undersigned, hereby authorize and direct Columbia Memorial Hospital to release written or verbal information concerning my hospital records to any insurance carrier or agent. Including Medicaid or Medicare, that is authorized to have access to and make copies of my hospital records.

( ) Yes ( ) No

Assignment of Insurance Benefits
I, the undersigned, authorize my insurance carrier to pay benefits. To which I am entitled, directly to Columbia Memorial Hospital. In the event I am entitled to benefits of any type whatsoever arising out of any insurance policy or governmental program (including Medicare or Medicaid) which provides payment for the hospital and medical care services which have been provided to me. I hereby assign such benefits to the Hospital and to such physicians who have provided me services to me in the connection with my care and treatment at Columbia Memorial Hospital.

( ) Yes ( ) No

Guarantee of Payment
I, the undersigned, do hereby guarantee full payment to Columbia Memorial Hospital for the hospital and medical services rendered. Payments shall be due in full upon presentation of a statement of the charge owed.
When it has been determined that insurance will no longer provide coverage we are obligated by law to notify the patient. In this case, it will be necessary for you to make alternate arrangements for payment. Every effort will be made by the hospital to assist you through our Patient Accounts Department.
You do have the right to request a review through your insurance carrier to appeal any determination. When Medicare is primary insurance carrier, the hospital may be subject to retroactive denial or payment of Medicare.

( ) Yes ( ) No

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness Date

_____ _____
Brief Reason for Visit Pharmacy for Today's Visit

COLUMBIA MEMORIAL HEALTH

HIPAA PRIVACY NOTICE

Acknowledgement

I, _____ acknowledge that I have been provided
Print Name
with a copy of Columbia Memorial Health's Privacy Notice.

_____ _____ _____
Signature Date DOB

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ hereby grant permission to discuss and/or
Print Name
release my medical information to:

_____	_____	_____
Print Name	Relationship	Telephone Number
_____	_____	_____
Print Name	Relationship	Telep hone Number

I, _____do _____ do not authorize the permission of my medical information to be left on my voice messaging system when necessary.

_____ _____ _____
Signature of Patient Date DOB

_____ _____
Witness Date

112309 / kp