Catholic Health System

- ❑ KENMORE MERCY HOSPITAL – Kenmore, NY
- ❑ MERCY HOSPITAL - Buffalo, NY
- ❑ MOUNT ST MARY'S- Lewiston, NY –effective 7/1/15
- ❑ SISTERS OF CHARITY HOSPITAL - Buffalo, NY
- ❑ SISTERS OF CHARITY HOSPITAL, ST. JOSEPH CAMPUS – Cheektowaga, NY

APPENDIX A

HOSPITAL CONSENT AND FINANCIAL AGREEMENT

AUTHORIZATION FOR PATIENT CARE: The undersigned patient and/or representative ("Undersigned") hereby grants permission to the employees of the hospitals of the Catholic Health System (CHS) to render routine patient care, and to carry out the orders of the patient's attending physician, consultants, associates, and assistants of the Undersigned's choice. For the purpose of advancing medical knowledge, the Undersigned understands that the hospitals of CHS provide a teaching environment to medical, allied health, and religious students and consents to such students participating in the patient's care.

RELEASE OF INFORMATION: The Undersigned hereby permits the Catholic Health System's facilities and agencies, the workforce of such entities, and the members of the System's various medical staffs, to disclose the patient's personally identifiable information for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and in the other circumstances listed in the System's Privacy Notice where federal law does not require my further Authorization. I have either received a copy of the System's Privacy Notice or one has been made available to me, which completely describes the circumstances in which the System does not require my further Authorization to disclose the patient's medical information. The Undersigned also grants permission to release medical information to other health care providers involved in the patient's care and to others involved in planning for the care of the patient. The Undersigned likewise grants permission for these parties to release appropriate medical information back to the Catholic Health System.

USE OF INFORMATION WITHIN THE CATHOLIC HEALTH SYSTEM: I understand the Catholic Health System is composed of numerous facilities and agencies including hospitals, nursing homes, adult care homes, home health care companies and related medical staffs. I further understand that in order for the Catholic Health System to effectively operate and to render appropriate health care, it may be necessary to use and review the patient's medical records and information retained at one or more of the facilities of the Catholic Health System. I therefore authorize the use of the patient's medical information by appropriate personnel and medical staff members within the Catholic Health System for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and for the healthcare operations of the Catholic Health System. Additionally, I understand that the Catholic Health System will include the patient's name, location, general condition and religious affiliation in its Patient Directories, such as a patient census and clergy report. I understand that the Catholic Health System may disclose Directory Information to members of the clergy and (except for religious affiliation) to individuals who ask for the patient by name. I do not object to the use of this limited information about the patient in Patient Directories.

ASSIGNMENTS OF BENEFITS: The Undersigned hereby certifies that all insurance information reported to the hospitals of CHS for this episode of care include all available sources of coverage, and assigns to the hospitals of the CHS, sufficient monies from said insurance to pay for the patient's care and treatment. The Undersigned further understands that regardless of assignment of these benefits, the Undersigned is personally responsible for the total charges for services rendered, and further agrees that all amounts are due and payable upon demand. The Undersigned further agrees that the hospitals of CHS retain the right to transfer monies from any credit balance account in the Undersigned's name to any other accounts which may be due and payable by the Undersigned.

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS: If applicable, the Undersigned hereby certifies that the information provided in applying for payment under Title XVIII of the Social Security Act is correct. The Undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers, any information needed for this or a related Medicare claim. The Undersigned requests that payment of authorized benefits are made on the patient's behalf. The Undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare for payment.

FINANCIAL AGREEMENT: In consideration of the services to be rendered to the patient on this date and all future dates, the Undersigned personally guarantees to pay the account of the hospitals of the CHS in accordance with the rates and terms established for the services rendered. The Undersigned also agrees that if the account remains delinquent and thereby requires the services of a collection agency and/or lawful authorities for collection, the Undersigned shall pay reasonable attorney's fees and collection expenses.

PERSONAL VALUABLES: I understand and agree that money, jewelry and other valuables should not be brought into the hospital, but if of necessity they are brought into the hospital, they should be deposited with the Cashier for safekeeping during working hours or the Nursing Supervisor after normal working hours. I further understand and agree that the hospital shall not be liable for the loss of or damage to any personal effects kept in my room during my hospital stay.

I have received the "Patient's Bill of Rights"/Health Care Proxy Information Packet:

Signature: _____

☐ I DO ☐ I DO NOT wish to have a private room during my hospitalization

CERTIFICATION: The Undersigned certifies that the Undersigned has read this form, and is either the patient, or has legal authority on behalf of the patient to execute the above and accept its terms; and that all information provided is accurate and complete to the best of the Undersigned's knowledge.

Date: _____Time_____ Patient Signature:_____

Representative Name (please print): _____

Representative's Signature: _____

Relationship of Representative to Patient: _____

The Signing of this Form Above, Witnessed by: _____

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICE HAS BEEN MADE AVAILABLE

ONE OF THE FOLLOWING SECTIONS MUST BE COMPLETED

1. To be completed by the Patient or the Patient's Legal Representative:

I hereby acknowledge that a copy of the System's Privacy Notice was made available to me.

_____ _____
Name of Patient Signature of Patient or Legal Representative

_____ _____
Name of Legal Representative (if signed by Legal Representative) Authority of Legal Representative (e.g., Healthcare Proxy, Guardian, Parent)

Date Signed _____/_____/_____Time _____

2. To be completed by the Health Care Provider: (Check One of the following Boxes)

☐ Patient Refused to Sign: I or a representative of the System exercised a good faith effort to obtain the signature on the above acknowledgement from the patient named below. Our good faith efforts to obtain such signature included requesting that the patient sign this acknowledgement at the time we provided him/her with a copy of the System's Privacy Notice. Despite our good faith efforts, the patient failed or refused to sign the above acknowledgement.

☐ Emergency: Treatment was delivered during an emergency and, therefore, the System was not obligated to obtain the patient's signature on the above acknowledgment. If the patient did not previously receive a copy of the System's Privacy Notice, Patient will receive a copy with their discharge instruction or as soon as practicable after the emergency is resolved.

_____ _____ _____
Name of System Representative Signature of System Representative Date Signed Time

CONSENT FOR HIV TESTING

I have been provided information about HIV and I accept testing.

☐ No, I don't want an HIV test at this time.

Signature: _____
Patient or person authorized to consent

LEAVING HOSPITAL AGAINST MEDICAL ADVICE

I certify that I fully understand and acknowledge that I am leaving the hospital against the advice of the Physician or Surgeon in charge of my case. I have been informed of the risks involved and I hereby agree to release and not hold the hospital, its agents, or servants or my physician or surgeon responsible for any harm or injury that may result because I have left the hospital.

_____ _____
Signature of Patient Date Time

_____ _____ _____
Witness Date Time

RELEASE OF RESPONSIBILITY FOR REFUSAL OF TREATMENT

I request that no _____ be used on me or administered to me during this hospitalization. I hereby release the hospitals, its personnel, and the Emergency Room physician from any responsibility whatsoever for unfavorable reactions or any untold results due to my refusal to permit the application of same. I have been fully advised of and understand the possible consequences of such refusal on my part.

_____ _____
Signature of Patient Date

_____ _____ _____
Witness Date Time