Gifford Medical Center

Patient Name: _____

D.O.B.: _____

Date of Visit: _____/_____/_____

MR #: _____

Rehabilitation
Patient Authorization Record

Please read carefully.

IMPORTANT INFORMATION
ABOUT YOUR HOSPITAL ADMISSION

CONSENT TO TREATMENT

Your hospital care will be provided according to your attending physician's orders. For major procedures, such as surgery, you will be asked to sign a separate consent form. By agreeing to be admitted/ ER treatment, however you are consenting generally to other medical treatments such as x-ray examinations, laboratory tests and minor procedures that are deemed necessary or advisable by the provider responsible for your care.

PERSONAL BELONGINGS

Gifford cannot be responsible for your personal belongings. If you wish to keep items with you in the hospital, you may request that they be placed in the hospital safe.

RELEASE OF RESPONSIBILITY FOR PARKED VEHICLE

I absolve the hospital from any and all responsibility for damage to, or theft of my vehicle as a result of being parked on hospital grounds. I hereby agree to hold Gifford Medical Center, its agents and servants, blameless for any liability incurred by virtue of my vehicle being parked on their premises.

RELEASE OF PATIENT INFORMATION

YOUR AUTHORIZATION

In many situations Gifford will not release patient-identifiable medical information outside this institution without your written authorization. You may revoke your authorization at any time (except the extent we have relied on it) by notifying Gifford in writing. If you do not revoke it earlier your authorization will expire one year after your last visit to Gifford. By signing below, you are authorizing Gifford to release medical information, which may include drug/alcohol abuse. HIV status, or psychiatric treatment, in the following situations:

INSURANCE COMPANIES

Gifford will provide medical information to your insurance companies, including Worker's Compensation, if applicable, as necessary to bill for and substantiate your hospital stay and the services you received.

SUBSEQUENT MEDICAL CARE PROVIDERS

Gifford will provide medical information to your physician, referring clinician and other health care providers, such as rehabilitation facilities, nursing homes, visiting nurses and home health care agencies, as necessary to continue your medical care after your hospital stay.

PAYING YOUR BILLS

ASSIGNMENT OF BENEFITS

If you have health care insurance or are entitled to Worker's Compensation benefits, you agree that Gifford may bill these insurers and they may make their payments directly to Gifford.

NON-COVERED CHARGES

You will be billed for all Gifford charges, which are not covered by your insurance.

FOR MEDICARE RECIPIENTS ONLY:

"I certify that the information given by me in applying for payment under Title XV111 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration and/or the Medicare program or its intermediaries or carriers or to the Professional Review Organization any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. My signature below only acknowledges the receipt of "An Important Message from Medicare" from Gifford Medical Center on the date listed below, and does not waive any of my rights to request a review or make me liable for payment."

TRICARE/CHAMPVA

If you are eligible for Tricare benefits, you have received a copy of the: "Important Message from Tricare."

I have read and understood the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions for admission to Gifford described above. If I am not the patient, I certify that I am authorized by law to agree to these Conditions of Admission on the patient's behalf.

_____ _____

Signature of Patient or Authorization Agent/Relationship if Agent Date

_____ _____

Signature of Witness Date