



**HOSPITAL CONSENT AND
FINANCIAL AGREEMENT**

Patient Identification Information

AUTHORIZATION FOR PATIENT CARE: The undersigned patient and/or representative ("Undersigned") hereby grants permission to the employees of Catholic Health System (CHS) facilities/services 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 facilities of CHS provide a teaching environment to medical, allied health, and religious students and consents to such students' participating in the patient's care.

ASSIGNMENTS OF BENEFITS: The Undersigned hereby certifies that all insurance information reported to all facilities of CHS and all clinical providers for this episode of care include all available sources of coverage, and assigns to the facilities of 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 facilities 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 AND/OR MEDICAID BENEFITS: If applicable, I hereby irrevocably assign payment of all CHS services and medical benefits applicable and otherwise payable to me to the designated CHS facilities and to all clinical providers providing care to me. I certify that the information provided in applying for payment under Title XVIII or XIX of the Social Security Act, is correct and request that payment of authorized benefits are made to the designated CHS facility and all clinical providers providing care on my behalf. 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/or Medicaid Services (CMS) or its intermediaries or carriers, any information needed for this or a related Medicare or Medicaid claim. 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 or Medicaid 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 designated CHS facility/service in accordance with the rates and terms established for the services rendered. The Undersigned also agrees that the CHS facilities and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication. The undersigned has been informed that many of the physicians at the CHS facility are privately practicing independent physicians, NOT CHS employees. These physicians (such as x-ray, emergency room, cardiology, etc.) bill separately from CHS for their professional services. 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. The undersigned has been made aware that the CHS Healthcare Assistance Program allows persons to receive medically necessary services at no charge or reduced charge, if they are eligible, at CHS facilities. Please call (716) 601-3600 to arrange for a payment plan.

PERSONAL VALUABLES: I understand and agree that money, jewelry, and other valuables should not be brought into CHS facilities. However, if out of necessity, valuables are brought into the hospital they should be deposited in the hospital safe by Security until the time of my discharge. Items brought into a CHS Long Term Care facility will be catalogued on the Resident Belonging sheet, appropriately labeled and any money deposited in the facility safe during my stay. Residents in long term care will also be provided a locked drawer upon request for personal belongings. I further understand and agree that the CHS facilities shall not be liable for the loss or damage to any personal property kept with me at CHS facilities during my stay. With respect to Home Care, I further understand and agree that CHS Home Care shall not be liable for the loss of or damage to any personal effects kept in my home unless there is proof of willful misconduct by a CHS associate.

I hereby consent to the above and acknowledge that a copy of the "Patient Bill of Rights"/Health Care Proxy Information Packet was made available to me.

Signature: _____ Date: _____ Time: _____

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.

Patient Signature: _____ Date: _____ Time: _____

Representative Name (please print): _____

Representative's Signature: _____ Date: _____ Time: _____

Relationship of Representative to Patient: _____

The Signing of this Form Above, Witnessed by: _____ Date: _____ Time: _____

COMPLETE PAGE TWO -HIPAA CONSENT

FS0019





Kenmore Mercy Hospital
 Mercy Hospital of Buffalo
 Sisters of Charity Hospital- Main Street and St. Joseph Campus

HIPAA Consent and Acknowledgment of Notice of Privacy Practice

RELEASE OF INFORMATION: The Undersigned hereby permits the CHS's facilities and agencies, the workforce of such entities, and the members of the CHS'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 CHS's Privacy Notice where federal law does not require my further Authorization. I hereby authorize and consent to release of all PHI; medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) to the CHS facility and to any and all clinical providers responsible for my care: interpretation of test results; account billing and collection; payment posting and/or processing; or related healthcare functions. 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 CHS.

USE OF INFORMATION WITHIN THE CATHOLIC HEALTH SYSTEM: I understand CHS is composed of numerous facilities and agencies including hospitals, nursing homes, adult care homes, home health care companies and related medical services. I further understand that in order for CHS 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 CHS. I therefore authorize the use of the patient's medical information by appropriate personnel and medical staff members within CHS for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and for the healthcare operations of CHS. Additionally, I understand that CHS 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 CHS may disclose Directory Information to members of the clergy and to individuals who ask for the patient by name (except for religious affiliation). I do not object to the use of this limited information about myself in facility Directories.

PATIENT ACKNOWLEDGEMENT FOR COMMUNICATION VIA THE PORTAL CONSENT. The Patient Portal will help you communicate with doctors, nurses and other support staff, allow you to see portions of your health information and in the future access to more types of information and communications. **Do not use the Patient Portal for serious medical problems. For an Emergency please call 911**

To be completed by the Patient or the Patient's/Client's/Resident's Legal Representative:

I hereby consent to the above and 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: _____

To be completed by the Health Care Provider: (If above is unable to sign)

Patient Refused/Unable to Sign: I or a representative of the Catholic Health 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 offered 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 Catholic Health 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

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