

My signature hereunder acknowledges my receipt of the Medicare/CHAMPUS Important Message from Woman's Hospital on the date below.  
My signature hereunder acknowledges my receipt of information describing my rights & responsibilities as a Woman's Hospital patient.

**MEDICARE-PATIENTS CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

**ASSIGNMENT OF INSURANCE BENEFITS TO PHYSICIANS**

I hereby assign to any physician providing anesthesia, pathology, radiology, neonatology or other services rendered in connection with my admission all benefits due me for such services under any applicable policy of insurance. I accept the financial responsibility to said physicians for all charges and services not paid by any payor or my insurance company and hereby promise to pay any remaining balance. The authorization to release medical information herein contained shall also apply to the physicians discussed in this paragraph. I also authorize and request my insurer to make payment directly to the physicians mentioned in this paragraph.

**(STATUS OF PHYSICIANS)**

I understand that my physician(s), the anesthesiologist(s), treatment room physician(s), pathologist(s), radiologist(s) or neonatologist(s) or other physician(s) who may treat me or my dependent or otherwise be involved in my or my dependent's care while a patient at the hospital are not employees or agents of the hospital and the hospital is not responsible for their actions. I further understand that my physician(s), the anesthesiologist(s), treatment room physicians, the pathologist(s), radiologist(s) or neonatologist(s) or other physician(s) will send me a separate bill for their services, in addition to the hospital bill.

**PERSONAL ITEMS**

It is understood and agreed that the hospital will, in an emergency situation, store valuables for safekeeping until said valuables are released to a person authorized by the patient. It is further understood that the hospital assumes no responsibility for personal articles under any circumstances.

**PHOTOGRAPHS OF INFANT**

By consenting to health care services for your infant at Woman's Hospital, you are also agreeing to permit photographs of your infant to be taken by your physician or other authorized personnel of Woman's Hospital. The photographs may be taken for reasons of infant security, treatment or diagnosis, bereavement or other purposes. The photograph(s), if any, will be maintained confidentially.

**PHOTOGRAPHS OF PROCEDURE**

By consenting to health care services at Woman's Hospital, you are also agreeing to permit photographs or videotapes to be taken during your procedure by your physician, his/her designee or other authorized personnel of Woman's Hospital. The photographs may be taken for purposes of diagnosis or treatment, medical education or other purposes. If the photographs or videotapes are used for any purpose other than your care, they will contain no identifying information. The photographs and/or videotapes, if any, will be maintained confidentially.

**PERSONAL RESPONSIBILITY FOR PAYMENT OF BILL**

I understand that I am personally financially responsible for the charges related to the service(s) I receive under the following circumstances: The service to be provided is a non-covered service, Woman's Hospital is not a network provider with my third party payor for this service (example: outpatient lab), I did not receive the required referral/authorization/precertification to access this facility/specialist, or my third party payor does not approve an additional hospital day(s).

\_\_\_\_\_ (patient or guarantor signature)

**CONSENT FOR TREATMENT**

I, the undersigned, agree to be admitted to Woman's Hospital for purposes of diagnosis or treatment as indicated by my treating physician/s. I authorize Woman's Hospital and any member of its staff to provide such medical service to me as may be necessary or desirable for the illness, condition or disease with which I am or may be afflicted. I further authorize Woman's Hospital personnel to perform such laboratory examinations of blood, serum, or other body fluids as may be necessary to confirm the presence or absence of communicable diseases including, but not limited to, hepatitis B, human immunodeficiency virus (AIDS), and syphilis.

I authorize Woman's Hospital to dispose of or bank any tissue, blood or any specimens surgically removed in accordance with usual and customary medical practice.

**(NOT APPLICABLE: \_\_\_\_\_)** I understand that Louisiana law (La. R.S. 40:1229.1) requires that certain tests be performed on all newborns, subject to the parent's right to refuse such tests. I hereby consent for my child to be subjected to all genetic, metabolic or other tests for newborns that have been approved by the Louisiana Dept. of Health and Hospitals, except \_\_\_\_\_

\_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

I have received a copy of the Woman's Hospital Notice of Health Information Privacy Practices. \_\_\_\_\_ (Initials)

**GENERAL ACKNOWLEDGEMENT**

I understand that I am to remain in the hospital until released or discharged by my physician or surgeon and that if I leave the hospital prior to such release or discharge, I assume complete responsibility and hereby release the attending physicians, surgeons, and hospital from all responsibility for any ill effect that may result therefrom.

I understand that the hospital is required by state law to report infectious transmissible diseases including sexually transmitted diseases to the state department of health.

This form has been fully explained to me. My signature reflects my understanding and acknowledgement of the information contained herein. I further understand and acknowledge that all references to myself as the patient shall be deemed to apply as if rewritten in their entirety to a dependent for whom I am responsible and/or who is unable to consent on her own behalf for the reason(s) indicated below.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE OF PERSON RESPONSIBLE FOR BILL:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

**PATIENT IS UNABLE TO CONSENT BECAUSE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_