

**ST. JOHN'S EPISCOPAL HOSPITAL
SOUTH SHORE**

**RELEASE OF INFORMATION/
ASSIGNMENT OF BENEFITS**

Addressograph

Release of Information – I hereby authorize and direct St. John’s Episcopal Hospital (“Hospital”) and or its representative having treated me to release to government agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Financial Agreement – The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services rendered to the patient, he/she hereby obligates him/herself to pay all amounts due for services presented in accordance with the rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay all reasonable attorney fees and collection expenses.

Assignment of Benefits – I hereby assign, transfer and set over to Hospital sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or other who are financially liable for my hospital, medical care and treatment rendered to me, my dependent or the insured by said Hospital. In addition, I assign benefits payable for physician services to the physicians or organization furnishing the services.

Assignment of Benefits for Patients Entitled to Medicare Benefits – I certify that the information given by me in applying for payment under the title XVIII of Social Security Acts is correct. I authorize any holder of the medical or other information about me to release to Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made on my behalf to St. John’s Episcopal Hospital. I assign the benefits payable for physician services to the physician or organization furnishing the services. In addition, I authorize the Hospital assignment of my Lifetime Reserve inpatient days should my Full Benefit and Co-Insurance inpatient days become exhausted.

The undersigned certifies that he/she has read the forgoing, and is the patient or is duly authorized by the patient as the patient’s agent to execute the above and accept its terms.

Patient Signature: _____ Date: _____
Parent/Guarantor: _____ Witness: _____
Relationship: _____

GENERAL ADMISSION / TREATMENT CONSENT

I, the undersigned, do hereby agree and give my consent for (my) (the indicated patient’s) admission to St. John’s Episcopal Hospital and I hereby request and authorize the above Hospital, the physicians on its Medical staff, the members of its House Staff and Nursing Staff, assisted by the employees of the Hospital, to provide such care and administer such diagnostic, radiological and/or therapeutic procedures and treatments as, in the judgment of the above physician(s) is deemed necessary or advisable in (my) the above patient’s care or (in the case of obstetrical patients) in the care of my newborn. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and withdrawal of blood for laboratory examination. I acknowledge the fact that the Hospital has the authority to dispose of specimens taken for laboratory or pathology examination. In addition, I hereby authorize any and all persons caring for me to review and/or release my personal health information to other healthcare providers treating me during this hospitalization. I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatments or examinations done in the Hospital.

Patient/Responsible Party Signature: _____ Date: _____
Next of Kin: _____ Relationship: _____
Other Person Responsible: _____ Relationship: _____
If the patient is unable to sign: Witness Signature: _____

ACKNOWLEDGMENT - I acknowledge receipt of the booklet, YOUR RIGHTS AS A HOSPITAL PATIENT IN NEW YORK STATE, prepared by the New York State Department of Health.

Signature: _____ Date: _____

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EMERGENCY TREATMENT CONSENT FORM



Authorization for Emergency Treatment - I hereby request and authorize St. John's Episcopal Hospital, the physicians and other personnel on its medical, nursing and other professional staffs, to administer such diagnostic tests and procedures, including diagnostic x-rays, drugs or other medications and to complete such routine therapeutic procedures as in the judgment of the physicians attending the patient deemed necessary or advisable in the treatment of the patient's emergency.

Patient/Responsible Party Signature: _____ Date: _____
Relationship: _____ Witness: _____

Telephone Permission for Emergency Treatment

Call Made By: _____ Telephone No.: _____
Person Called: _____ Relationship: _____
Permission given? [] Yes [] No Call witnessed by: _____
Name/Title

Authorization for Emergency Department Procedures - I further authorize and consent to the following special procedure(s):

(DESCRIBE THE PROCEDURE IN THE LANGUAGE OF THE LAYMAN)

The risks, benefits and alternatives of the proposed procedure(s), including the risks of refusing the proposed procedure(s) have been explained to me.

Patient/Responsible Party Signature: _____ Date: _____
Relationship: _____ Witness: _____

Telephone Permission for Emergency Department Procedure

Call Made By: _____ Telephone No.: _____
Person Called: _____ Relationship: _____
Permission given? [] Yes [] No Call witnessed by: _____
Name/Title

Notice of Privacy Practice – I hereby acknowledge receipt of the Hospital's Notice Privacy Practice.

Patient Valuables – It is understood and agreed that the Hospital cannot accept any responsibility for the loss or damage of articles which the patient or legal representative consider valuable. The Hospital has no provisions for the safekeeping of money or other valuables and these should either be kept at home or kept in the safekeeping of family or friends.

I release the Hospital from any and all liability for the loss or damage to any "valuables" which I may choose to retain in my assigned room or any storage area therein, despite the warning and advice on this document

Patient/Responsible Party Signature: _____ Date: _____
Relationship: _____ Witness: _____