



GENERAL CONSENT FOR TREATMENT

CONSENT TO ADMISSION, EXAMINATION, AND TREATMENT: I consent to necessary and advisable diagnostic and therapeutic procedures and hospital care for the patient, by the Hospital, the patient's physician, and their assistants and designees. I acknowledge that the practice of medicine and surgery is not an exact science and that no guarantees have been made as to the results of the hospital care and medical treatment. I acknowledge the fact that the Hospital has the authority to dispose of specimens taken for laboratory or pathological examination.

GUARANTY OF PAYMENT: I shall be fully responsible for the payment of the patient's hospital bill, based upon the Hospital's posted charges. The Hospital may demand full payment of the patient bill at any time although the Hospital's failure to demand immediate payment shall not release my obligation to make such payment. If insurance benefits for the patient, which have been assigned to the Hospital, do not pay for any or all of the hospital and medical care rendered, I understand and agree that I may be fully responsible for the payment of the balance due.

PHYSICIAN FEES: I understand that Physician fees are not included in the patient's Hospital bill. The physician(s) involved in the care will bill directly for their professional services.

ASSIGNMENTS OF INSURANCE BENEFITS: I assign, and set forth to the Hospital monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered, but not to exceed the Hospital's regular charge for this care.

MEDICARE ASSIGNMENT: I understand that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize release of information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of physician(s) for whom the Hospital is authorized to bill. I understand I am responsible for any deductibles, copayments and co-insurance under this act.

CREDIT BALANCE: I understand that credit balances which occur in my favor, on this account may be applied by the Hospital to reduce any other outstanding account for which I am responsible.

RELEASE OF INFORMATION / NOTICE OF PRIVACY: I hereby authorize the Hospital to disclose all or any part of the patient record, as allowed and/or mandated by law.

I acknowledge receipt of the St. Luke's Cornwall Hospital Notice of Privacy Practice.

I give my permission to the Hospital to use the patient's name in the general course of treatment, for example, to identify me, and, as applicable, my room number, on patient boards/treatment schedules.

The Hospital may use the patient's name at the information desk to allow visitation and/or personal telephone calls.

I Agree I Disagree

PERSONAL PROPERTY RELEASE: I release the Hospital from all liability for the loss or theft of, or damage to the patient's personal property unless it has been deposited with the Hospital for safe keeping as evidenced by written receipt.

THIS FORM HAS BEEN EXPLAINED TO ME TO MY SATISFACTION AND I UNDERSTAND ITS CONTENTS.

Patient/ Relative/ Guardian*	Print Name	Relationship to Patient	Date	Time
Interpreter (if required)	Print Name	Date	Time	
Witness	Print Name	Date	Time	

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.