MedStar Good Samaritan Hospital

The Good Samaritan
Hospital of Maryland, Inc.
5601 Loch Raven Boulevard
Baltimore, MD 21239-2995

PLACE PATIENT ID STICKER HERE

## CONSENT FOR MEDICAL TREATMENT:

I hereby authorize the personnel of this hospital and members of it's medical staff to render to the patient whose name appears on this form such care as they deem necessary and appropriate.

## AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize this hospital to release my final diagnosis and other medical information to the third party payers identified to determine benefits payable.

## ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment to this hospital of any insurance, personal injury protection or other benefits otherwise payable to me or the patient. The undersigned acknowledges the responsibility for any coinsurance, deductible or other sum nor received by the hospital from any third party source.

## GUARANTEE OF PAYMENT:

I acknowledge financial responsibility for any health insurance deductible, coinsurance or failure for any reason of any insurance carrier to pay the hospital's charges in full when rendered. I also acknowledge that interest may be charged to unpaid balances over thirty days form the date payment is due. In the event that the account is referred for collection, I agree to pay all reasonable collection and attorney fees required to collect any delinquent balance.

## PHYSICIAN CHARGES:

I understand that in addition to any bills I may receive pertaining to facility (hospital) charges; I may also receive bills on behalf of the physicians who participate in my care. These physician charges are not included in the bill from the hospital. (Note: when verifying your insurance coverage for your hospital stay, please verify your coverage for the physician groups that may contribute to your care.)

## PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION: (Applies to Medicare Patients Only):

I hereby certify that the information given by me applying for payment under TITLE XVIII and XIX of the Social Security Act of third party payers is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or a related Medicare Claim. I hereby authorize MedStar to use my sixty (60) lifetime reserve days Medicare coverage. I have received an important message from Medicare.

## PERSONAL VALUABLES:

Patients are encouraged to leave all money and other valuables at home. This hospital shall not be responsible for the loss of or damage to any personal property the patient has brought into the hospital including dentures and glasses.

## PATIENT RIGHTS AND RESPONSIBILITIES:

I have received information about Patient Rights and Responsibilities.
Notice of Privacy Practices:
My initials acknowledge that I am in receipt of the MedStar Privacy Practices Brochure _____

## ADVANCE DIRECTIVES AND LIVING WILL:

A PHOTOCOPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

I certify that I understand the contents of this form.

| Witness | Patient's Signature | Date | Time |
|---|---|---|---|
| | | | |

| Date | Time | Authorized Person's Signature | Date | Time |
|---|---|---|---|---|
| | | | | |

## SMOKING CESSATION:

Has the patient smoked any time during the past year?

☐ NO ☐ YES

☐ If YES, smoking cessation literature was provided.

## ADVANCE DIRECTIVE:

When asked whether or not the patient has formulated an Advance Directive, the undersigned has responded (check one):

- ☐ Yes, and a copy included in Medical Record
- ☐ Yes, but a copy has not been presented
- ☐ No, but would like additional information
- ☐ No, and not interested in more information

The undersigned acknowledges that the hospital has taken the following action, if requested:

- ☐ Information regarding Advance Directive has been provided.