CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY AND SIGN THE NECESSARY AUTHORIZATIONS, RELEASES AND AGREEMENTS SO THAT WE MAY PROCEED WITH THE CARE AND TREATMENT ORDERED BY YOUR PHYSICIAN/PROVIDER.

1. **CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s)/provider(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s)/provider(s).

2. **MEDICAL EDUCATION**: I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.

3. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST**: I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.

4. **FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.

5. **HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer's or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.

6. **CONSENT TO WIRELESS TELEPHONE CALLS:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to 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 from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. **CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.

8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.

9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficient Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital. If for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood, I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.

10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS / OTHER HEALTH CARE PROVIDERS:** I understand that: Most of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Many physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, physician assistants (P.A.'s), Nurse Practitioners (N.P.'s), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) may be independent contractors and not employees, representatives or agents of the Hospital. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors.

    _____ Initials of patient / patient representative

    I understand that I am under the care and supervision of my attending physician/provider. The hospital and its staff are responsible for carrying out my physician's/provider's instructions. My physician, provider, or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's/provider's general and special instructions.

    I understand that physicians/providers providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.

12. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.

    □ I object to having my name, location and general condition listed in the facility directory.

13. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.

14. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask for additional information.

USE LABEL OR PRINT PATIENT ID HERE

15. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my doctor or provider before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of your medical record.

16. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

    ☐ I have executed an Advance Directive, if applicable

    ☐ I have not executed an Advance Directive

    ☐ I would like to formulate an Advance Directive / receive additional information

17. **OTHER ACKNOWLEDGEMENTS:**

    a. **Personal Valuables:** I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables and that the hospital shall not be liable for the loss of such valuables unless deposited with the hospital for safekeeping. The liability of the hospital for loss of personal property that is deposited for safekeeping is limited to $500.00 or the maximum required by law. I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/iPods/tablets and all other such devices.
    b. **Smoke Free Facility Policy:** The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.
    c. **Weapons/Explosives/Drugs:** I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found the items may be confiscated, disposed appropriately or tumed over to the law enforcement authorities.

18. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient, Legal representative for health care if other than Patient	Date	Time
Relationship of Representative	Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent	
Signature of Witness	Date	Time

USE LABEL OR PRINT PATIENT ID HERE

Primary Care Provider

Please list your Primary Care Physician/Provider or Provider Group. This is the Physician/Provider you see for routine visits, wellness exams and/or minor health concerns.

____

(Write Physician or Physician Group name above)

__________Initial here if you **DO NOT** have a Primary Care Provider. Thank you!

______________________________ ____________ ____________

Signature of Patient/Legal Representative Date Time

Médico de atención primaria

Por favor anote quién es su médico de atención primaria (llamado "PCP" en inglés) o grupo que le da atención primaria. Es el médico o profesional de la medicina a quien usted ve en consultas generales, en exámenes anuales y/o para inquietudes menores sobre su salud.

____

(Escriba sobre la línea el nombre del médico o del grupo que le da atención médica)

__________Ponga sus iniciales en el espacio en blanco si **NO TIENE** Médico Primario. ¡Gracias!

______________________________ ____________ ____________

Firma del paciente o representante legal Fecha Hora

Free, fast, secure and confidential . . . **MMC created "My Healthpoint" for You!**

You can now access important information about your recent hospital stay as an inpatient or through the Emergency Department online.

INCLUDING:

- Procedures performed during your stay
- List of current and past medical issues
- Discharge instructions
- List of current medications and your medication history
- Laboratory results
- Additional valuable information

Simply provide your **email address:**____

If you do not have an email address or do not wish to provide it at this time, please initial one of the following:

______I do not wish to provide my email address at this time

______I do not have an email address

Thank You for choosing MMC as your Healthcare Provider!

Gratis, rápido, seguro y confidencial . . . **¡MMC creó "My Healthpoint" para usted!**

Ya puede tener acceso a información importante acerca de su hospitalización reciente (como paciente internado y también sobre visitas a la sala de emergencias).

INCLUYENDO:

- Los procedimientos que se le hicieron mientras estuvo hospitalizado
- La lista de sus problemas médicos actuales y anteriores
- Las instrucciones que recibió cuando le dieron de alta
- La lista de las medicinas que usted toma actualmente y el historial de las medicinas que ha tomado
- Los resultados de los análisis de laboratorio
- Otros datos valiosos

Sencillamente anote su **dirección de correo electrónico:**__________________________________

Si no tiene dirección de correo electrónico o no quiere darla en estos momentos, por favor ponga sus iniciales en una de las opciones que aparecen a continuación:

______No quiero dar mi dirección de correo electrónico en estos momentos

______No tengo dirección de correo electrónico

¡Gracias por poner a MMC al cuidado de su salud!

My Healthpoint E-Mail Request 862-102 (New 06/14) Page 1 of 1 U R F O R M Memorial Medical Center Las Cruces, NM	USE LABEL OR PRINT PATIENT ID HERE

“Our mission is to care for you with compassion and respect.”

At anytime during your stay, you have the right to request a discharge evaluation, to include your need for and the availability of post-hospital services.

Questions or concerns regarding quality of care, abuse, neglect, or exploitation may be directed to the New Mexico Department of Health at:
Telephone Hotlines: 1-800-752-8649 or 1-800-445-6242
Adult Protective Services: 1-866-654-3219

Hotline Hours of Operation
Monday – Friday
8:00 am to 5:00 pm
(Mountain Time)
(Closed weekends and state holidays)

Quality of care concerns may also be directed to the Joint Commission at 1-800-994-6610
Email: compliant@jcaho.org
(Hours of operation: 8:30-5:00 Central time, Monday – Friday)

§ *ALL INFORMATION IS KEPT CONFIDENTIAL* §

PATIENT/REPRESENTATIVE SIGNATURE: ______________________________

DATE: ____________

*****SIGNATURE ABOVE ACKNOWLEDGES RECEIPT OF INFORMATION*****

Hot Line Notification 651-222 (Rev. 08/12) Page 1 of 1 ADMHOTL Memorial Medical Center Las Cruces, NM	USE LABEL OR PRINT PATIENT ID HERE