HackensackUMC
Maternal Fetal Medicine & Surgery

AFFIX PATIENT INFO LABEL HERE

Patient Name_____ MR# _____

OUTPATIENT CONSENT FORM

1. **CONSENT TO CARE:** I wish to be treated by and/or admitted to **Hackensack University Medical Center.** While I am a patient, I give permission to my doctor(s), the hospital employees, and all the persons caring for me to provide care in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatments. I understand that the Medical Center is a teaching hospital and that under the appropriate supervision medical students, fellows and residents of the University of Medicine and Dentistry of New Jersey, **Hackensack University Medical Center,** or other teaching affiliates may participate in my care and treatment but I may decline such participation. The University of Medicine and Dentistry of New Jersey medical students, fellows and residents are employees of the state of New Jersey. I understand that no guarantees have been made to me about the outcome of this case. I hereby authorize **Hackensack University Medical Center** to preserve and use for scientific and/or teaching purposes, or dispose of any specimens or tissues taken from my body during hospitalization and hereby waive any clam or right I may have in such specimens or tissues.

2. **INDEPENDENT PHYSICIANS:** I understand and agree that: (i) the physicians who participate in my care and treatment at Hackensack University Medical Center are Independent contractors or private practitioners who have been granted the privilege of using Medical Center facilities for the care and treatment of their patients; (ii) these physicians are **not** the agent or employee of **Hackensack University Medical Center** and (iii) **Hackensack University Medical Center** is not in any way responsible for the judgment or conduct of any physicians providing medical services at the hospital. While physicians who practice at **Hackensack University Medical Center** must admitted to the staff and continue to meet certain educational and experience requirements, I agree that **Hackensack University Medical Center** is not responsible for the care provided to me by them.

3. **PATIENT RIGHTS:** I acknowledge that I have received a copy of the *New Jersey Patient Bill of Rights and an Advance Directive Brochure.*
ADVANCED DIRECTIVE: Federal and State law require hospitals to ask the following questions of all adult patients being registered to their facility.
Do you have an Advance Directive or Living Will for healthcare? ☐ Yes ☐ No ☐ N/A
Name of Healthcare Proxy *(If Applicable)* _____
Was a copy of the document provided at the time of registration? ☐ Yes ☐ No

4. **RELEASE OF INFORMATION:** The Medical Center may see, release to and/or confirm, all or part of any financial and medical information, **including information regarding psychological, psychiatric, HIV and related diagnosis, drug and/or alcohol related illness,** with any person, corporation or government agency that is or may be responsible to the hospital, the patient, and family member or employer for all or part of the Medical Center's charges or verification of the same. I acknowledge that the Medical Center may verify my address through a database search of the Federal Credit Reporting System. I acknowledge that the Medical Center may be required to release patient information, **including the highlighted above,** to federal and state agencies that monitor healthcare facilities, as well as any industries that produce and/or manufacture medical products. I consent to the release of my name, general condition and room telephone number when requested. I authorize **Hackensack University Medical Center** to provide access to my medical information to any person or organization in order to facilitate the provision of post hospital care, treatment or services. I acknowledge that **Hackensack University Medical Center** may access patient information from my medical record for purposes of research. I acknowledge that I have been informed that I may be contacted to participate in research study and that I have the right to agree or decline to participate.

5. **PRE-CERTIFICATION REQUIREMENTS:** I understand that if I do not comply with my insurance policy pre-certification requirements or if any admission is not certified, I will be responsible for any and all hospital charges.
Please check the appropriate box: (*Pre-Certification)*
I acknowledge that the pre-certification requirements I am responsible for have all been met. ☐ Yes ☐ No ☐ N/A

6. **ASSIGNMENT OF BENEFITS:** I authorize my health insurance benefits to be paid directly to **Hackensack University Medical Center.** Under the terms of my policy this payment may not exceed the balance due for services performed during this period or treatment. I further authorize **Hackensack University Medical Center** to appeal on my behalf any denial by my insurance carrier.

7. **FINANCIAL AGREEMENT:** When billed, I agree to make prompt payment to **Hackensack University Medical Center** for any and all charges not paid by insurance benefits, to the fullest extent permitted by law. I understand that the Medical Center bill applies only to hospital charges and does not include any charges or fees by physicians. I agree that any physician charges or fees are in addition to hospital charges. I understand that some or all of the physicians who participate in my car may not participate in my insurance plan. I understand that I should call my insurance company if I have questions about insurance coverage.

8. **DEPOSIT REQUEST:** A deposit has been requested of me because I will be paying for all and/or part of the hospital bill. The Medical Center's acceptance of partial payment does not relieve you of responsibility for the full amount.

9. **NEW JERSEY HOSPITAL CARE ASSISTANCE PROGRAM:** I have received a copy of the notice of New Jersey hospital care assistance program.

10. **MEDICARE 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 the direct payment of authorized benefits be made on my behalf. I assign benefits payable physician's services to the physicians or organization furnishing the services or authorize such a physician or organization to submit a claim to Medicare for payment.

11. **OUTPATIENT SERVICE "MEDICAID":** I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for hospital services to the **Hackensack University Medical Center** and the benefits payable for physician services to the physician or organization furnishing, the services or authorize such physician or organization to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

I have read the information contained above, any question I had have been answered, and I understand its contents. I attest that my personal information provide to **Hackensack University Medical Center** is correct. I understand that providing incorrect information for the purpose of avoiding payment or for any other reason may be considered a violation of state and/or federal law.

I understand that this form will be valid for the period of one year from the date signed for all outpatient services. I also understand that I have the right to ask questions at any time regarding my treatment, care of any terms contained on this consent. If I wish to revise my consent, I may do so by completing a new form or if I wish to wishdraw my consent, I must do so in writing.

Patient	*Date and Time*	*Guarantor (if other than Patient)*	*Date and Time*
Next of Kin/Power of Attorney (if applicable)	*Date and Time*	*Relationship of Guarantor (if applicable)*	*Date and Time*
Witness	*Date and Time*		