WESTERN WISCONSIN HEALTH

Assignment of Benefits / Consent to Treatment

1. **Consent to Treatment:** I recognize that I may have a health care condition requiring medical care, diagnosis, and treatment, and voluntarily consent to medical care and treatment as ordered by my health care provider. I understand that this care will be under the direction of a Medical Staff Member of Western Wisconsin Health. This consent includes hospital services, diagnostic procedures, and all medical treatment rendered under the instructions of my health care provider, including x-ray and laboratory procedures and other tests, treatments, or medication, monitoring, and all other procedures that do not require my specific informed consent. I recognize that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made as to the result of treatments or examinations administered. I understand I may be released from the medical center before all of my medical problems are known or treated, and that it is my responsibility to make arrangements for follow up care.

2. **Responsibility to Refuse Treatment:** Each patient has the right to consent to or refuse any proposed procedure or therapeutic treatment. I understand I should speak to my healthcare provider if there is anything I do not want done. The healthcare provider will explain the nature of my condition and treatment and the other ways that this condition could be treated, if any. He/she will explain significant risks involved with the treatment, if any.

3. **Financial Agreement/Assignment of Benefits:** I request that payment of authorized benefits for treatment at WWH be made on my behalf to, and hereby assign benefits directly to Western Wisconsin Health. I hereby assign the benefits payable for the provider services to the provider/organization furnishing this service or authorize such provider/organization to submit a claim to Medicare for payment to me. I authorize Western Wisconsin Health or its agent, to release any and all information from my medical records need for payment of my claim. I understand I am financially responsible to the medical center for charges not covered by this assignment and agree to pay those charges. All charges are payable in full 30 days from date of discharge/service or third-party payment. In the event that legal action is necessary to collect this account, I agree to pay reasonable attorney fees and collection expenses, including interest.

4. **Health Care Education:** I understand and agree that the hospital maintains affiliation agreements with academic institutions and that at times, health care services may be observed and/or delivered by students under the supervision and responsibility of the attending health care provider or other authorized medical center personnel.

Please Place a Current Admission Sticker Here When Available

Patient Name: _____

Date of Birth: _____Med Rec #: _____

5. **Consent to Photograph:** I understand that photographs, videotapes, digital or other images of me may be recorded for the purpose of treatment and/or documentation in my record. I hereby consent to the use of these images for this stated purpose only. I also understand that if WWH or others request to photograph or take images of me for any purpose, a written consent to do this must be obtained from me prior to being done.

6. **Personal Valuables:** Patients are discouraged from bringing valuables to the medical center. Western Wisconsin Health will not be responsible for valuables not deposited in safekeeping.

7. **Information Privacy:** I understand that Western Wisconsin Health will use and disclose my personal health information for treatment, to receive payment for the care I receive, and for other health care operations. I understand that a Notice of Privacy Practices document that provides a more complete description of information uses and disclosures is available for me to receive. The terms of this privacy notice may change with time and the medical center will post the current notice at its facilities, on its web site and have copies available for distribution. I acknowledge that I have access to and/or received a copy of the medical center's Notice of Privacy Practices.

8. **Patient Rights:** I understand that I have access to the Patient Rights.

9. I have read the above and understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

_____ _____

Patient Signature **Date / Time**

OR Parent/Guardian or Legal Representative Signature

_____

Relationship to patient, if patient is unable to sign

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