GENERAL CONSENT TO TREATMENT

The undersigned patient, or patient’s representative, requests admission to Island Hospital for care and treatment. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment or examination in the hospital. I consent to and authorize the following:

MEDICAL CONSENT: I consent to all medical and surgical treatment, X-ray, laboratory, anesthesia and other medical and hospital procedures performed or prescribed by the attending physician during this hospitalization.

ADVANCE DIRECTIVE: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for health care.

RELEASE OF MEDICAL INFORMATION: I authorize Island Hospital to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to this hospitalization. I also consent to the release of any information as needed for post-discharge care or transfer to other health facilities or agencies as I direct or as required by law.

FINANCIAL AGREEMENT: I certify that the information given in applying for payment under government or private insurance is correct. I understand I am financially responsible to the hospital for charges not paid under this agreement. Island Hospital reserves the right to impose reasonable financing and late charges as well as reasonable costs, attorney fees and expenses incurred in the collection of my account should it become delinquent. Financial responsibility will be reduced or waived if charity care eligibility is determined.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Island Hospital of the hospital benefits, including major medical insurance coverage.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized 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 payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

PERSONAL VALUABLES: I acknowledge that the hospital maintains a safe for the safekeeping of money and valuables of small size and shall not be liable for the loss or damage of any money, jewelry, documents or other small articles of value unless deposited for safekeeping.

Patient or other Legally Responsible Person

Witness

Relationship of Legally Responsible Person to Patient

Date

Island Hospital • 1211 24th Street, Anacortes, WA 98221-2590 • (360) 299-1300

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ISLAND HOSPITAL 5501

Rev. 1/10

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