[x] Great River Health System
[ ] Southeast Iowa Regional Medical Center
[ ] FM/WB [ ] FM campus [ ] WB campus
[ ] Henry County Health Center

[ ] Family Planning
[ ] Rural Health
[ ] Non-HBC Clinic
[ ] Department Specific

Universal Consent to Treat

CONSENT TO TREATMENT: I consent to services that may be performed by Southeast Iowa Regional Medical Center (SEIRMC) and/or all associated clinics. This consent and agreement apply to services performed by a provider on SEIRMC's medical staff at all locations. Additional consents may be necessary and will be explained. I understand I can cancel this consent at any time.

MEDICAL PHOTOGRAPHY: If the treatment performed requires medical photography, I consent to such medical photography and consent to the use of these photographs and any other records for my medical care, for research, or for educational purposes without compensation to myself or my family so long as such will preserve anonymity.

STUDENTS: Medical, nursing and other health care trainees may assist in patient care unless I request otherwise.

PERSONAL ITEMS: I understand I am responsible for personal property I bring with me including, but not limited to, money, jewelry, glasses, dentures, electronic devices, documents, or other valuables. I release SEIRMC and/or all associated clinics from all responsibility for such things. I understand a safe is available for storing valuables.

FINANCIAL AGREEMENT: I agree for myself or on behalf of the patient to promptly and fully pay for services and supplies provided by SEIRMC and/or all associated clinics, and others. I understand I am responsible to pay all charges at the regular rates if they are not covered or promptly paid by insurance for myself, my spouse or minor child. I understand I am responsible for providing accurate insurance information at the time of service. If this is not done, I will be responsible for paying the full amount. I understand my credit score may be checked for likelihood to pay. This will not affect my credit rating.

ASSIGNMENT OF BENEFITS: I allow SEIRMC and/or all associated clinics, and others under contract or arrangement to receive payment for services provided by Hospital and its employees or others working under contract or arrangement with it (including but not limited to radiology services, reference labs, etc.) and to the physicians who accept assignment and their employees for all insurance coverage and benefit available under any government program, insurance policy (including but not limited to health insurance, workers compensation, automobile insurance or other third party coverage), or other benefit program.

I direct all benefits be paid directly to the hospital and the physicians at the address(es) provided for payment. I agree the hospital and physicians may directly receive payments and discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting in payments or other resources may be applied to any other account owed by the patient or the undersigned. These assignments may not be cancelled for services provided during this hospitalization.

MEDICARE CERTIFICATION AND ASSIGNMENT (Medicare Patients): I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in SEIRMC and/or all associated clinics. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

AUTHORIZATION FOR RELEASE OF INFORMATION: I give permission to share information as necessary to receive payment for services, perform utilization review and other hospital operations, and provide follow-up care. Information may be released to any person or organization that is responsible for paying my bill or reviewing my information. This includes insurance companies, workers compensation parties, employers, family members, and governmental or private review agencies.

I understand this release cannot be cancelled for any records relating to services provided during this hospitalization, except as explained below. I understand SEIRMC and/or all associated clinics will protect the confidentiality of medical information, but I release SEIRMC and/or all associated clinics from liability when responding in good faith to an apparently valid request for information. I have the right to inspect my information and to obtain an accounting of disclosures.

SPECIFIC CONDITIONS: I agree and acknowledge SEIRMC and/or all associated clinics may release information about **drug or alcohol abuse, mental health treatment and HIV/AIDS-related information** as necessary to receive payment for services, perform utilization review and other hospital operations, and provide follow-up care for services. I understand I may cancel this authorization by giving written notice to the Health Information Management Department. I understand information released before cancelling this authorization will not be considered a breach of my right to confidentiality.

COMMUNICATION CONSENT: I understand providing my contact information means I am giving permission to contact me through several methods of communication including, but not limited to, home telephone, cellular telephone, texting, emailing, automated telephone dialing system, and recorded voice messages. Communication could include, but not limited to, reasons related to services provided, future services, and calls related to collections of amounts owed for services. This consent extends to outside organizations that are working as agents of SEIRMC and/or all associated clinics including, but not limited to, collection agencies. I am not required to provide contact information to receive services. I may cancel my consent by giving written notice to the Patient Billing Department.

NOTICE OF PRIVACY PRACTICES: I have received or have been offered a copy of the Notice of Privacy Practices, which describes when the health system may use or share information for treatment, payment and health care operations. I understand notice is provided the first time I receive services and then only when a significant change is made. Otherwise, it is available by request and on the health system's website.

HEALTH INFORMATION EXCHANGE (HIE): SEIRMC and/or all associated clinics participate in HIEs to make patient information available electronically to participating hospitals, doctors, and other participants. We may also receive information about patients from other participants in the HIE. You may choose to opt-out of HIEs by calling the Health Information Management Department at 319-768-1900.

PATIENT'S RIGHTS AND RESPONSIBILITIES: I have been informed of and have received or have been offered a statement of my patient rights and responsibilities including visitation rights, my right to accept or refuse medical care and my right to formulate an advance directive.

By signing below, I certify that I have read and understand this form and accept its terms and conditions, and that I am signing as a patient or as patient's authorized representative.

Signature of patient or legal/responsible representative	Date	Relationship if not signed by patient