Brigham & Women's Faulkner Hospital **1153 Centre St** **Boston, MA** **02130-3446** **617-983-7000**	**Name:** **CSN:** **Date of Service:**

GENERAL CONSENT FOR TREATMENT AND/OR ADMISSION TO THE HOSPITAL

TO OUR PATIENT: Brigham & Women's Faulkner Hospital, and other Partners-affiliated hospitals (collectively, "the Hospitals"), physician groups, and affiliated group practices provide services and facilities to help your physician when you need surgical procedures, diagnostic and therapeutic procedures, inpatient hospitalization, or outpatient services. If you undergo specific procedures or operations, you have the right to have each procedure explained along with its risk and alternatives.

REQUEST FOR OUTPATIENT SERVICES: (if applicable) I am seeking outpatient medical services. I request that the hospital and its affiliated physician groups provide care and related necessary procedures and treatment. I have been provided with information about preventing infections and have had an opportunity to ask questions

REQUEST FOR HOSPITALIZATION: (if applicable) My physician(s) has determined that I have a condition for which hospital admission has been recommended. I request care and related diagnostic procedures and medical treatment necessary in the judgment of my physician or his/her assistant.
If applicable, I request and authorize my physician(s) to make any provision for medical and surgical care which is deemed necessary or advisable for my newborn(s). If I have a Primary Care physician on file, **Brigham & Women's Faulkner Hospital** will notify them of my admission. Please let your healthcare team know if you'd like to have your family member, or delegate, contacted upon your admission.

BELONGINGS: (if applicable) I understand that the hospital maintains a safe for safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, radios, furs, computers, or other small portable articles of value, unless placed for safekeeping in the hospital's safe. Any personal property that I keep with me at the hospital shall be at my own risk, and the hospital shall not be liable for any loss or damage to it.

CARE IN A TEACHING HOSPITAL: Because these are teaching hospitals, residents and interns who are licensed physicians; nursing, medical and other students participate in patient care and may function as a necessary part of the patient care team under careful supervision of a senior physician, nurse, or other health professional. I agree to this participation. I am under no obligation to participate in any activity the primary purpose of which is educational, and my personal wishes will control the extent of my participation in this regard.

PRACTICE OF MEDICINE: I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding outcomes of treatments or examinations in the hospital.

VIRTUAL CARE: Virtual care enables the remote provision of clinical care services, using telecommunications technologies such as video conferencing or telephone. A virtual care service offers the ability for your provider to treat you, or consult with another provider about your care, without being in the same physical location. The primary difference between virtual care services and in-person services is the inability to have direct, physical contact with the provider. I understand that some clinical needs may not be appropriate for virtual care and my provider will make that determination. I understand that virtual care treatment has potential benefits including, but not limited to, easier and safer access to clinically appropriate care; however, I have the right to choose in-person treatment instead. I understand I have the right to refuse or discontinue virtual care services and to be informed of all parties who will be present at each end of the virtual care service. You may be financially responsible for virtual care services as determined by your insurance company.

To the extent possible, the electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality, privacy, and security of patient data. In rare events, security protocols could fail, causing an unintended disclosure of protected health information. I understand there are other potential risks to using virtual care technology, including but not limited to, interruptions and technical difficulties.

DISPOSITION OF EXCESS MATERIAL: (if applicable) I understand that blood or other specimens removed for necessary diagnostic or therapeutic reasons may later be disposed of by **Brigham & Women's Faulkner Hospital**. These materials also

may be used by the Hospital, or other academic or commercial entities, for research, education purposes (including photographing), or other activity, if in furtherance of the Hospital's missions.

DISCLOSURE OF MEDICAL INFORMATION FOR PURPOSES OF REIMBURSEMENT AND/OR CONTINUITY OF TREATMENT: I authorize the hospital and its affiliated group practices to release any information from my medical records that may be needed for the settlement, by third party payers, of all claims for payment by the hospital and physician groups.

I understand that for the purposes of coordination and continuity of my medical care, it may be necessary to disclose information about my treatment. I authorize the disclosure of information from my medical records as is reasonably deemed necessary for such purposes.

I request that direct payments be made to the hospital on my behalf by insurers and agencies in the settlement of such claims.

MANAGED CARE PATIENT FINANCIAL RESPONSIBILITY FORM

As a member of a Managed Care Plan, I understand that all of my medical care is to be coordinated by my Primary Care Physician (PCP), subject to any exceptions in my member agreement. If specialty services are necessary, they must be approved by my PCP, subject to any exceptions in my member agreement.

I acknowledge that if I do not have a valid referral from my PCP, including an authorization number, if required, for the specialty care I am about to receive, I will be responsible for payment for services if the payment is denied on that basis by my health insurance company.

I also understand that it is my responsibility to ensure that the service I am about to receive is a benefit covered by my health insurance member agreement. If the service is not a covered benefit, I will be responsible for payment of these services.

The above is subject to the provisions of existing agreements between "the Hospitals" (see above), its affiliates, and my health insurer.

MESSAGE TO MEDICARE PATIENTS

The physicians of the Hospitals believe in the value of preventative medicine and annual physicals. However, Medicare does not cover the cost of routine physicals and various screening tests and requires us to bill you for this type of service. We are required to bill your routine physical and/or routine screening tests as just that, and not bill it out under any other diagnosis you may have. We can be fined if we misrepresent the diagnosis, when in fact this visit is for a routine examination.

If, at any time of your physical, certain problems are active and require adjustment in medication or new tests to be performed, Medicare will pay for charges relative to that problem only. However, you will still be responsible for the difference between the Medicare allowed amount and the charge for the routine physical.

Brigham & Women's Faulkner Hospital must honor Medicare Guidelines. If you anticipate these rules will represent an unbearable financial hardship for you, please discuss this with one of our financial counselors.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT: (1) that I have read and understand the information provided in this form, (2) that any questions I had have been asked and satisfactorily answered, (3) that I hereby request and give my consent to medical care and treatment including, if applicable, any necessary diagnosis procedures and treatment, including virtual care services. (4) I have received the Patient Bill of Rights, including visitation information if I am being hospitalized.

Patient Signature:

Signature of Patient Representative: