Consent for Diagnosis and Treatment: I hereby consent to the provision of all medical treatment and other health care that my physician(s) or other caregivers consider necessary, which may include diagnostic, radiology, and laboratory procedures provided to me at any WakeMed location. I understand that this consent is valid for up to two years. If I am or may be pregnant, I agree to tell my practitioner and hereby consent to radiology imaging (e.g. x-ray, CT, etc.) and other treatment, as agreed with my practitioner.

Independent Practitioners and Students: I understand and agree that many physicians and other individuals involved in my care at WakeMed are independent contractors in private practice, are not employed by WakeMed, and that WakeMed is not liable for their acts or failures to act. This includes, but is not limited to: emergency room, anesthesia, radiology, and laboratory physicians and other practitioners; students, interns, residents, and fellows; constant observers; and many other physicians, health care providers, and non-clinical staff. I understand that I may receive separate bill(s) from one or more independent providers or groups who were involved with my care. I also recognize that WakeMed is a teaching institution, and I agree that students training to be physicians, nurses, or other health care professionals may assist in providing my care.

Use and Release of Medical Information: I acknowledge that WakeMed, its staff, and other independent physicians and health care professionals involved in providing my care at WakeMed are authorized to use and release my medical information for purposes of treatment, payment and health care operations as stated in WakeMed's Notice of Privacy Practices.

Patient's Certification: I certify that the information provided in applying for payment under Medicare, Medicaid, or any other government programs or insurance benefits is complete and accurate in all respects and agree that I am financially responsible to WakeMed if it is not.

Guaranty of Payment: I understand that I will be financially responsible for and hereby agree to pay and to guarantee payment in full of any and all charges for services provided by WakeMed, independent groups, physicians, or other health care professionals involved in providing treatment or consultation to me, even if such treatment is not covered by insurance. In the event of nonpayment, I agree to pay, and do hereby guarantee the payment of, all costs of collection, including reasonable attorneys' fees. I understand that my bill(s) will be sent to the address on file unless I submit a complete written request for my bill(s) to be sent to an alternate address.

Irrevocable Assignment of Insurance Benefits: I, on behalf of myself and the patient, in consideration of health care services provided, voluntarily and irrevocably assign and authorize direct payment of all surgical and medical benefits directly to WakeMed and WakeMed Physician Practices (WPP). I also authorize payment of applicable benefits directly to all physicians or other practitioners involved in my care, including but not limited to independent physicians and groups practicing at WakeMed (e.g. emergency medicine, radiology, anesthesia, laboratory/pathology, and certain surgeons, physicians, and other practitioners and groups). Benefits assigned shall include, but may not be limited to, major medical insurance, liability insurance (including excess, umbrella and automobile uninsured/underinsured coverages), medpay and personal injury protection (PIP) benefits.

I understand this assignment means that WakeMed can and will seek and receive direct payment from any potential insurer or other payment source, which may limit what I can recover personally for my injury. I further understand that until my charges are properly paid by some insurer, I and the patient remain personally responsible for all charges. I authorize WakeMed, as necessary, to endorse benefit checks made payable to me and/or WakeMed or independent practitioner(s). I understand and agree that in carrying out these functions, WakeMed is acting for its own benefit to obtain payment and is not required to act for my benefit. I further understand that should any of my charges not be covered by any insurer for any reason, including a determination that they were not medically necessary, I and the patient remain personally responsible for full payment. If my health insurer is not the entity making payment, I agree that any contractual discount may not apply.

Overpayments and Refunds: I authorize return or payment of any overpayment received within WakeMed's sole discretion. If any refund becomes due to me or to the patient, I authorize WakeMed to apply any such amount(s) to any charges that remain outstanding for services provided to me or the patient (or for which either of us is legally responsible) at any time as allowed by law.

Assertion of Lien: I, for myself and the patient, voluntarily and irrevocably agree that, if any claim or lawsuit is made against any liability, medpay, uninsured, or underinsured motorist insurance coverage(s) related to injuries/loss for which I received care at any WakeMed or WPP location, WakeMed may seek and perfect a lien against said claim and/or recovery to the fullest extent allowed by law and may seek payment of its full and undiscounted charges from any and all proceeds to be paid from any of the insurance coverage set out above. I, for myself and the patient, further agree to provide WakeMed with the name, address, policy number and claim number for every insurance carrier that may provide liability, medpay, uninsured and underinsured insurance coverages. I understand that if I fail to do so, I may be responsible personally for WakeMed undiscounted charges and the charges of other professionals who provide care and treatment.

Release of Liability For Valuables: I understand and agree that WakeMed cannot assume liability for money or valuables (e.g. cell phones, jewelry, purses, glasses, cash, medications, or other personal property) brought to its facilities, including into a patient room or treatment area. Money and valuables should be sent home with a family member or close friend. If anyone chooses to keep money or valuables with him/her, these items are that person's responsibility and I agree that WakeMed is not liable if they are lost, damaged, or stolen. Clinical and nursing staff cannot accept valuables for safekeeping.

Termination of this Consent: I understand that I may withdraw my consent as to future actions at any time by notifying WakeMed in writing, but such notice will not affect actions already taken based upon my prior consent or which are noted above to be irrevocable (meaning consent cannot be withdrawn). I understand and agree that such action may result in the patient and me being responsible for payment of all charges, which may not be subject to any reduction, adjustment, or discount.

"White Board" Consent: Certain areas of WakeMed (including the Rehab Hospital) use a small, dry-erase board called the "White Board." The "White Board" is a tool used by members of your treatment team to communicate information about your current functional status and other care-related issues. The "White Board" is updated frequently to help assure accurate communication between care providers. Specific information may include your level of independence or assistance needed for eating, talking, walking, transfers, using the bathroom, bathing, and other tasks. Visitors to your room may see this information, but we are requesting your consent to use this team communication to help ensure you receive the care and support you need. If you have concerns about use of the "White Board," please talk with your care team.

WakeMed Rehab Hospital Medicare Assessment and/or Program Evaluation Information *(applicable to patients in the Rehab Hospital)*: The federal government requires rehabilitation hospitals to submit demographic, financial, and clinical information to Medicare to verify that the rehab services provided are reasonable and necessary. The information submitted will be entered into a Patient Assessment Instrument, which you may request to review. Additionally, WakeMed submits information to an external evaluation agency to monitor the effectiveness of our rehabilitation programs. The information collected is considered confidential and will be disclosed only for legitimate purposes allowed by law. You may be contacted by this external agency to gather information about our rehabilitation program and your experience, but you are not required to answer any question(s).

I understand and agree to the above statements, releases, authorizations, and assignments of benefits. If I am signing this for a patient other than myself, any reference to "I" or "me" includes me and the patient.

Signature (Seal): _____Date: _____ Time: _____ Guardian or Representative, if any: _____
(Patient or legal guardian/closest available relative/authorized representative, if patient unable to sign) *(Please print name)*

Signature (Seal): _____ Date: _____ Time: _____
(Insured/Guarantor, if different from Guardian/Relative/authorized representative)

Name of Insured/Guarantor or Representative, if any: (printed) _____

Acknowledgement of Receipt of the WakeMed Notice of Privacy Practices

If I am a first-time patient, I certify that I have received a copy of the WakeMed Notice of Privacy Practices. If I am a returning patient, I certify that I have been offered a copy of the WakeMed Notice of Privacy Practices.

Signature: _____ Date: _____ Time: _____ ☐ Signature obtained after initial registration

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Staff Use Only: Consent to Diagnosis and Treatment Obtained By Telephone

Treatment / procedure: _____

_____

Authorized Person Giving Consent: _____ Telephone #: _____

Relationship to Patient: _____

Witness: _____ Witness: _____

Date: _____ Time: _____ Date: _____ Time: _____

Staff Use Only:

☐ Patient unable to sign due to condition and/or level of consciousness

☐ Patient refused to sign after receiving Privacy Notice

☐ For ED use only (Privacy Notice given to minor/caretaker in absence of parent)

☐ For ED use only (unable to sign due to emergency transfer to another hospital)

☐ Other _____

Completed by: _____ Date: _____ Time: _____
