MID COAST HOSPITAL

Patient Name:
Date of Birth:
Date of Visit:
Medical Record #:
Patient #:

CONSENT TO TREATMENT

I. Consent to Treatment

I authorize Mid Coast Hospital, its health care practitioners and staff, to examine me and perform any tests, procedures and/or treatments that may be helpful to care for my injury or illness. Images (x-rays, medical procedure videos or photos) may be taken during my stay and become part of my medical record.

I understand that the health care practitioner responsible for my care will explain any proposed procedures or treatments, including their usual and most common risk and hazards. I also understand that I have the right to refuse any planned procedure or treatment.

I understand that many of the physicians on the staff of Mid Coast Hospital, including some attending physician(s) are not employees or agents of the hospital, but rather, are independent contractors who have been granted the privilege of using the facilities for the care of the treatment of their patients.

I understand that I may complete an Advance Directive. An Advance Directive allows me to direct the type of care that I will receive if I become unable to decide for myself. It also allows me to choose someone to make those decisions for me.

I release Mid Coast Hospital from any responsibility for valuables, money, personal, and other possessions. If admitted to the Hospital the hospital safe is available to you at no charge. If items are not deposited in the hospital safe Mid Coast Hospital is released from any responsibility.

II. Release of Health Care Information

I understand that information concerning my evaluation and treatment is available to those involved in my care or as required by law, including other health care facilities. I authorize Mid Coast Hospital to develop my plan of care, continue my care/treatment and provide education related to my follow-up care. I understand that Mid Coast Hospital has an electronic medical record. This record can be viewed by authorized staff at different locations when they become involved in my treatment or plan of care.

I also authorize Mid Coast Hospital and its contracted agents to release my health care information to the extent necessary to my insurance carrier(s) and their reviewers or others paying for this care. This consent is in effect until final payment is received, unless cancelled.

Under Maine law, providers may disclose some health care information to certain people. All of these disclosures are limited to the amount of information reasonably required for the purpose of the disclosure. I understand that Mid Coast Hospital will release information to the specific recipients below unless I have crossed them out:

- **Primary Care Physician and/or any provider participating in my care**
- **Family or Household Members**
- **Hospital Directory** (when a hospital patient- name, room number, and health status)
- **Clergy** (when a hospital patient- name, room number, place of residence, and religion)
- **Media if requested** (when a hospital patient- name, general health status)

I also authorize the Patient Satisfaction vendor of Mid Coast Hospital and Mid Coast Medical Group to contact me by telephone (this may be auto-voice) and/or other methods to survey me about my recent visit.

III. Payment and/or Assignment of Benefits

I understand that I am responsible for paying all costs associated with my evaluation and care. If I have health insurance, I understand that I am financially responsible for those charges not covered by my insurance such as deductibles, co-pays, or full payment for those evaluations or treatments that are not included as an insurance benefit.

I authorize my health insurance carrier(s) to pay the costs associated with my evaluation and care directly to Mid Coast Hospital. Mid Coast Hospital will release my health care information, to the extent necessary, to my insurance carriers.

I have been informed that this consent may be revoked at any time by written communications to my attending physician or nurse. I acknowledge the fact that such revocation will not be effective for action already taken in reliance upon such consent. In addition, if consent is revoked and payment is denied that patient agrees to pay all charges.

IV. Specialized Releases

State and Federal laws require my specific consent to disclose information within Mid Coast Hospital or outside Mid Coast Health pertaining to:

- HIV testing or treatment
- Mental health diagnosis treatment
- Drug and/or alcohol or other substance abuse treatment
- Genetic Testing Information
- Domestic violence or sexual assault

I understand that I may refuse authorization to disclose all or some health care information within Mid Coast Hospital, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

I understand that my record may contain information pertaining to HIV testing or treatment, mental health, and/or substance abuse treatment. I may withdraw this consent at any time, except to the extent that information has already been released. This consent will terminate in one year from date signed.

V. Patient Rights and Responsibilities

I understand that I have rights as a patient that include: the right to be treated with dignity and respect, to have effective communication, to privacy, and pain management. In addition, when admitted to the Hospital, I have the right to have visitors of my choosing and religious or spiritual services. I have the right to be free from discrimination.

I understand I am responsible for providing accurate information, asking questions when I do not understand the treatment course or care decisions. I will follow instructions, policies and rules as explained to me by the staff. I will comply with all safety instructions and will treat staff with respect and dignity.

_____ _____

Signature of **Patient** Date/Time

_____

Patient Name Printed

_____ _____

Signature of **Legally Authorized Representative** **State the relationship**