Consent to Medical Care and Treatment: I consent to all medical and surgical care, examinations, and tests which are determined to be necessary for me while I am a patient at OhioHealth. I understand that the practice of medicine and surgery is not an exact science and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as to the result(s) of any treatment, procedure, or examinations to be performed on me while I am a patient of OhioHealth.

Refusal of Treatment: I understand that if I refuse treatment that is suggested for me or I do not complete a treatment protocol recommended to me, I will not hold OhioHealth nor any individual responsible for the consequences of my refusal or incompletion.

Release of Information: I authorize OhioHealth to disclose copies of all or any part of my medical records obtained in the course of my diagnosis and treatment to any insurance carrier, workers compensation carrier, welfare agency, or any other entity, which may be providing financial assistance for my hospital, medical and/or nursing care. I understand that this disclosure may include information concerning Human Immunodeficiency Virus (HIV) testing, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related condition(s), psychiatric condition(s), and/or alcoholism or drug abuse. I also authorize the release of medical information for utilization and quality assurance review to my insurers or their subcontractors and as required by any city, state, or federal laws. I authorize this facility to disclose medical information to my family physician, referring physician, or any other provider directly involved in my medical care. I hereby give my express consent to OhioHealth and its agents to contact me at any phone number (including my cellular phone number) that I have given to OhioHealth personnel for a legal purpose related to my care at OhioHealth and any other recommended follow up or future care, by means including the use of either automatic telephone dialing systems or other computer-assisted technology.
This consent is subject to written revocation by the patient or without revocation will expire one year from this date.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me or the patient named below, I hereby assign to OhioHealth all right, title, and interest in and to any third-party benefits due from any and all insurance policies employee benefit plans and/or responsible third-party payers in an amount not to exceed OhioHealth's regular and customary charges for the health care services rendered. I authorize such payments from my insurance carriers, third-party payers, and any other third-parties. I consent to any request for review or appeal by OhioHealth to challenge a determination of benefits made by a third-party payer, insurance carrier or employee benefit plan. Except as required by law, I assume responsibility for determining in advance whether the services provided to me are covered by my insurance or other third-party payer.

Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between OhioHealth and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the patient named below, I agree to be financially responsible and obligated to pay OhioHealth for its total charges not paid under the "Assignment of Benefits" made below. Any balance due for any hospitalization for which I have agreed to be financially responsible must be paid upon discharge from the hospital. All other balances must be paid within thirty (30) days after receipt of a statement. I understand that I will be responsible for the costs of any services rendered to me that are not eligible for benefits under Medicare, Medicaid, insurance or other payors.

Statement to Permit Payment of Medical Benefits to Provider and Physician(s): I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers any information need for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to OhioHealth and to physicians and groups providing medical care to me.
Tobacco-Free Information: Tobacco use of any kind is not allowed inside or outside of OhioHealth's central Ohio facilities. Compliance with OhioHealth's tobacco-free policy is expected of all patients and visitors.
Privacy Notice: I have been offered a copy of OhioHealth's Notice of Privacy Practices within the past year.
Personal Valuables: OhioHealth is not responsible for any lost, stolen, or damaged personal items.
Nondiscrimination Statement: OhioHealth complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ethnicity, religion, culture, language, age, disability, socioeconomic status, sex, sexual orientation, and gender identity or expression in its health programs and activities.
For Hospital Patients Only:

- Teaching Hospital: I understand that this facility is a teaching hospital and I consent to allow medical students, interns, residents, fellows, nurses and other health care personnel assisting and/or participating with my physician(s) in the performance of the diagnostic, medical, and surgical procedures which may be performed upon me under my physicians' direction and supervision.
- Price Information: I understand that I am entitled to Hospital price information as stated in Ohio Revised Code 3727.12.
- Home Health, Hospice and Durable Medical Equipment (DME): I understand that I have the freedom to choose and the right to select my provider/supplier for post-discharge care that I may need. I am aware that, in order to improve continuity and quality of care, the hospital will generally use HomeReach or another OhioHealth affiliate for home health care, hospice services, and DME after discharge unless I select a different provider/supplier. I understand that I will be given a list of other available home care agencies in my Admission/Registration packet and that I may ask a discharge planner for another copy of the list or express my preference for a different provider at any time.
- Patient Rights: I was provided a copy of the "Patient's Rights" information. This form can also be found at www.ohiohealth.com.
- Advanced Directives: I was provided with a copy of OhioHealth's information on Advanced Directives. This form can also be found at www.ohiohealth.com.
- I acknowledge that I was given the opportunity to opt-out of the facility directory and provided with additional information as requested.

Acknowledgment
By signing below I acknowledge that I have read and understand this Consent and Authorization and that I have been given the opportunity to ask questions and receive clarification so that I fully understand and agree to this Consent and Authorization:

Patient Name (printed): ______________________ **Date of Birth:** ____________

PATIENT SIGNATURE ______________________ DATE ________ TIME ________

SIGNATURE OF PATIENT'S AUTHORIZED REPRESENTATIVE ______________________ DATE ________ TIME ________

SIGNATURE OF WITNESS TO REPRESENTATIVE'S SIGNATURE ______________________ DATE ________ TIME ________

1CNT

PATIENT IDENTIFICATION LABEL

GENERAL CONSENT

3000029FF (10/12/2016)