NANTUCKET
COTTAGE HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

MR#
PT NAME
ACCT#

Patient Identification Area - Please Place Sticker Here

Nantucket Cottage Hospital

Consent & Authorization Form

A. CONSENT FOR TREATMENT (Please Circle One): OUTPATIENT INPATIENT ER

I hereby consent to be admitted/treated as a patient at Nantucket Cottage Hospital for the purpose of receiving medical care and treatment and/or diagnostic procedure.

1. I am aware that all attending physicians are given privileges to practice at Nantucket Cottage Hospital but not all physicians are agents or employees of the Hospital.
2. I understand that I have the right to consent or revoke consent, in writing, for any proposed procedure or therapeutic treatment and that discussion of the risks, benefits, and alternatives to each procedure is available to me.

DATE: _____ **PATIENT SIGNATURE:** _____

RESPONSIBLE PARTY OTHER THAN PATIENT SIGNATURE: _____

B. AUTHORIZATION FOR PAYMENT:

I hereby authorize payment to Nantucket Cottage Hospital of all insurance benefits including but not limited to federal & state programs, VA, and TRICARE and assign my rights thereunder to Nantucket Cottage Hospital. I understand that I am personally responsible to pay to Nantucket Cottage Hospital all amounts billed for the services I receive that are not paid by these insurance benefits as well as deductibles and coinsurance. If my account is not paid, I will pay all costs including, but not limited to, attorneys' fees and court costs expended in collection efforts. I authorize Nantucket Cottage Hospital to utilize my Medicare Part A lifetime day coverage and Outpatient Medicare Part B coverage, when necessary. I have received "Medicare Message to Patients." **Initial:** _____

C. AUTHORIZATION FOR RELEASE OF INFORMATION:

1. I understand that there may be times when Nantucket Cottage Hospital is required to give or receive information relating to my hospitalization or my outpatient treatment.
2. I agree that Nantucket Cottage Hospital, and/or their authorized designated record review and processing representatives may give information concerning my hospitalization or my outpatient treatment to my insurance company and/or referring physician(s), including information listed in the section below.
3. I understand there are certain highly confidential records that can not be released without my specific written consent and an authorized release for, under Massachusetts State Law and Federal Law.
4. I agree that Nantucket Cottage Hospital may obtain and/or release all necessary information about me, including highly confidential clinical and coded information, to assist in my care or treatment or to appropriately bill me or others who have provided medical care to me or are responsible for this payment of all or part of my bill.
5. I understand that the authorization and consents in this form are on file at the Hospital and shall apply to my current admission, on-going outpatient care, and such other services as are required in the continuation of treatment. This authorization shall be valid for the time necessary to process reimbursement claims pertaining to this specific account.
6. I **give** or **do not** give consent to notify clergy of my hospitalization. **Initial:** _____

D. PERSONAL VALUABLES:

1. I understand and accept responsibility for all personal property retained by me in the Nantucket Cottage Hospital.
2. I have been advised not to keep any valuables with me, as the Hospital will not be responsible for lost items.
3. Nantucket Cottage Hospital reserves the right to inspect and/or prohibit inappropriate or unsafe items such as drugs, alcohol, weapons, cellular phones, etc. **Initial: _____**

Patient Signature_____ **Date**_____

Witness_____

Responsibility Party Other Than Patient (Only if patient is a minor or is incapacitated)
Signature_____ **Date**_____
Relationship to Patient_____

Witness_____

INPATIENT ADMISSIONS ONLY

☐Yes ☐No I am requesting a private room and in so doing, I accept financial responsibility for the difference between the Private and Semi-Private Room Rate which exists at the time of my hospitalization.

_____ I have received copies of "Notices of Privacy Practices", "Your Rights As a Patient" and "Decisions Concerning Your Medical Care". I understand my rights and that I can execute a Health Care Proxy in accordance with Massachusetts General Laws, Chapter 201D, which allows me to authorize a designated agent to make health care decisions in the event I am unable to do so myself.

_☐_ I do have a Health Care Proxy (Advance Directive).
Location: _____

_☐_ I do not have a Health Care Proxy, but am interested in learning more about this.

_☐_ Health Care Proxy Received.

_☐_ Health Care Proxy declined on this date.

Patient Signature_____ **Date**_____

Witness_____

Responsibility Party Other Than Patient (Only if patient is a minor or is incapacitated)
Signature_____ **Date**_____
Relationship to Patient_____

Witness_____

***** Subject to the Patient's rights pursuant to privacy rules, the Hospital does not agree to modifications to this Authorization form unless stated in writing.**