Penn Medicine
Lancaster General Health

Patient Name: ______________________
MRN: ______________________
Date of Birth: ______________________
Complete above information or attach patient label to each page.

Patient Name: ______________________________

CONSENT TO TREATMENT

1. I hereby voluntarily consent to receiving medical services at Lancaster General Hospital or Lancaster General Health, including: diagnostic and therapeutic procedures, telecommunications technology (also known as "telemedicine"), examinations, hospital care, and medical and/or surgical treatment as deemed necessary or advisable by my physician(s).
2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding the result of my treatment or examination in the hospital. I am aware that I may refuse any drugs, treatments, and/or procedures offered to me.
3. I understand that the Emergency Department physicians, Anesthesiologists, Radiologists, and other physicians providing care may be independent physicians, and may not be employees or agents of Lancaster General Health. I will be billed separately for services provided by these physicians as well as any Lancaster General Health employed physicians.
4. I hereby authorize Lancaster General Health to release all information, including all or any part of my medical records, to my insurance company, employer (Workmans' compensation only), Medicare, Medicaid, liability insurance (including excess, umbrella and automobile uninsured/underinsured coverages), Medical Payments/Personal Injury Protection benefits or any other fund or third party payer which may be responsible for payment of benefits on my behalf.
5. While a patient at Lancaster General Health, I understand that I am responsible for the maintenance and safekeeping of personal medical equipment, cash, and possessions.
6. I hereby assign and grant to Lancaster General Health all rights and interests to which I may be entitled under any insurance policy, Medicare, Medicaid, liability insurance (including excess, umbrella and automobile uninsured/underinsured coverages), Medical Payments/Personal Injury Protection benefits or any other fund or third party payment plan responsible for payment of my benefits.
   I authorize payment of any such benefits directly to Lancaster General Health.
7. I agree that I am responsible for payment of Lancaster General Health's established charges currently in effect to the extent that said charges are not covered, allowed or paid by my insurance company, Medicare or any other fund or third party payer, I may be asked to pay such fees at the time of my visit. I understand that I will not be responsible for the payment of any of those charges that Lancaster General Health is restricted from collecting by law or agreement.
8. I consent to the photographing or video recording of appropriate portions of my body during my assessment, operation, or procedure for medical, scientific, educational, or quality improvement purposes. I understand that Lancaster General Health will ask my permission prior to taking any photographs or video recordings and I may refuse to be photographed or video recorded at any time.
9. Consent to use and disclose personal health information: I understand and consent that Penn Medicine Lancaster General Hospital is permitted to use and disclose health information about me in any form including electronic for treatment, payment, and healthcare operations and as otherwise allowed by law. This includes sharing my health information with Penn Medicine Lancaster General Hospital or outside providers involved in my care, and family members or friends involved in my care.
10. I consent to automated or live communications to my phone number – either land line or cell – for communications related to my healthcare services and billing.
11. In connection with the care provided, and to the extent any potential claim for payment is governed by ERISA (Employee Retirement Income Security Act), I transfer and assign on behalf of myself and the patient all claims of any kind which I or the patient may have for payment of benefits. I further assign to Lancaster General Health all rights to seek and receive payment for all charges related to my care and treatment. This assignment includes all rights to pursue all administrative appeals of any kind and I specifically appoint Lancaster General Health and their representatives as my representative for such actions.

LANCASTER GENERAL HEALTH MAY OBTAIN THIS CONSENT ON AN ANNUAL BASIS.

____ ______________ ______________
Patient or Legally Authorized Representative* Signature | Date | Time

☐ Patient unable to give written consent. Verbal consent obtained.

____
Patient or Legally Authorized Representative Printed Name

____ ______________ ______________
Witness Signature | Date | Time

____
Witness Printed Name

* If a legally authorized representative is consenting for the patient because the patient is a minor or unable to consent, complete one of the following:

(a) Patient is a minor who is ________ years of age, and the signer's relationship to the minor-patient is: ______________________.

(b) Patient is unable to consent because ______________________________, and the signer's relationship to the patient is: ______________________.