HELEN HAYES HOSPITAL

Route 9W, West Haverstraw, NY 10993

Ambulatory Care Service
Consent for Treatment

CONSENT FOR TREATMENT: **Patient Name:** ______________________________

I hereby enter the above named patient, whose relationship to me is that of ___________________________, as a patient in the Helen Hayes Hospital, West Haverstraw, NY, and am agreeing to allow treatment, procedures and/or diagnostic studies to be performed as the attending physician or their designee deem to be necessary. This may include transfer to another facility if considered necessary for proper medical care in the opinion of my attending physician or designee. I understand that no guarantees or assurances have been made to me as a result of my medical care and treatment.

Signature: ____ **Relationship:** _________________________

Witness: ____ **Date:** _______________________________

NOTICE OF PRIVACY PRACTICES AND PATIENTS' BILL OF RIGHTS
I acknowledge that I received a copy of the Hospital's Notice of Privacy Practices and Patients' Bill of Rights.

Initials: ____

USE AND DISCLOSURE OF INFORMATION:
I consent to the use and disclosure of my health information for treatment, payment and healthcare operations.

ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to Helen Hayes Hospital of any hospital or medical insurance benefits otherwise payable to me. Such payments, however, are not to exceed the balance due such provider based upon the regular customary charges for services.

MEDICARE BENEFICIARIES ONLY:
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 Centers for Medicare and Medicaid Services (CMS) or its Intermediaries or Carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians or organizations furnishing the services or authorize such physicians or organizations to submit a claim to Medicare of payment for me.

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Signature: ____ **Relationship:** _________________________

Witness: ____ **Date:** _______________________________

GUARANTEE OF PAYMENT AGREEMENT
The undersigned hereby unconditionally guarantees the payment of the hospital and physician bill arising out of this admission and treatment of the above patient. The undersigned further certifies that he/she has read the foregoing and is the patient or guardian of the patient or is the duly authorized agent to execute the above conditions and accept its terms.

Print Responsible Party Name: _______________________ **Relationship:** _________________________

Signature of Responsible Party: ____

Witness: ____ **Date:** _______________________________