St Luke's PHYSICIAN GROUP

GENERAL CONSENT

1. I have presented myself for treatment to a St. Luke's University Health Network facility and consent to routine medical care provided by that facility. I acknowledge that because medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatment in this facility.

2. I understand that this consent does not include informed consent for operations or any non-routine procedures or treatment and that risks and alternatives for such procedures or treatment, which is a reasonable patient would consider significant to a decision whether not to undergo such treatment or procedures, will be explained to me by my treating physician or another physician designated by him/her. I understand I have the right to refuse any drugs, treatment or procedure to the extent permitted by law.

3. I authorize the facility to use and disclose my health information: (1) to other health care professionals who are involved in my treatment either now or in the future; (2) to any insurance company or other entity as necessary for the facility to be paid for the services provided to me; and (3) for the general administrative activities of the facility, such as quality control and peer review.

4. I have provided the facility with my true and correct medical insurance information and I hereby assign and transfer to the facility or medical provider benefits payable and any related rights existing under those insurance policies. I authorize and direct the insurance company to pay all such benefits to the facility. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurance company and the facility.

5. I understand that this facility is a teaching facility or is one that supports professional education training, that those involved in training programs may be participating in my care, and I consent to their presence and participation in my care.

6. I have been advised not to keep valuables on my person or in my room and if I am an inpatient, to have them locked in the facility. I will not hold the facility responsible for any valuables that I keep on my person or in my hospital room at the time of admission or during the service.

7. I hereby authorize the facility to dispose of all tissue, blood, and other organic matter in the facility's normal and routine method for disposing of such matters, including the use of blood and tissue for the internal purpose of gathering and sorting data or human tissue by categories to be available for potential use in research studies. If my information is to be used for a research study, I may ask to sign additional authorization at that time.

8. I have the right to file a grievance in writing or in person to administration. If the grievance is not resolved to my satisfactions, I may contact one of these organizations: Pennsylvania Department of Health (800-254-5164), Quality Insights of Pennsylvania (800-322-1914), or The Joint Commission (800-994-6610).

9. Medicaid Patients: My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of materials may be prosecuted under applicable Federal and State laws.

10. You have the right to choose who may visit you during your inpatient stay regardless of whether the visitor is a family member, friend, or domestic partner. You have the right to change or withdraw your visitor's privileges at any time by notifying the nurse caring for you.

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND COMPLETELY THE INFORMATION ON THIS CONSENT; THAT ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND ANY STATEMENTS NOT APPLICABLE HAVE BEEN CROSSED OUT AND INITIALED PRIOR TO MY SIGNATURE.

_____ _____

PATIENT SIGNATURE PATIENT PRINTED NAME

_____ _____ _____ _____

SIGNATURE OF AUTHORIZED PERSON/LEGAL GUARDIAN DATE TIME RELATIONSHIP

_____

PRINTED NAME OF AUTHORIZED PERSON/LEGAL GUARDIAN