CONCORD HOSPITAL

250 Pleasant Street, Concord, NH 03301
(603)225-2711 www.concordhospital.org

TREATMENT AUTHORIZATION AND ADMINISTRATIVE ACKNOWLEDGMENT

AUTHORIZATION FOR TREATMENT: I authorize my provider(s) or his/her designee(s) or consultant(s), in charge of my care at Concord Hospital, to provide services deemed necessary or advisable in the diagnosis and treatment of my condition(s). I understand that I may withdraw this authorization for treatment at any time before a procedure, test, or medication is administered.

In cases of emergency, I understand that the need for prompt medical attention may prevent authorization of a more detailed or specific nature before proceeding. In this circumstance, I authorize my provider(s) and their designee(s) to administer such anesthetics and perform such operation and procedures as they deem necessary.

I understand and agree to the following:

1) Concord Hospital may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes;
2) Any tissues or parts surgically removed may be disposed of by Concord Hospital in accordance with the customary practice; and,
3) No guarantee has been made as to the results of care provided.

ELECTRONIC MEDICAL RECORD ACKNOWLEDGMENT: Concord Hospital primarily uses electronic medical record systems to capture medical information in both the inpatient and outpatient settings. These systems allow my information to be available to my healthcare providers and the staff at Concord Hospital, Concord Hospital Medical Group practices, and other providers who are involved in my care, which would include my primary care provider, specialty care providers, consulting providers, on-call providers, emergency/urgent care providers, hospitalists and other hospital-based providers. Concord Hospital is committed to protecting my privacy in accordance with applicable state and federal laws. A complete description of how my health information may be used and disclosed is contained in the Concord Hospital Notice of Privacy Practices, available to me upon request.

HEALTH CARE EDUCATION: I acknowledge that Concord Hospital is a teaching institution, and health care workers in training are important members of my health care team. I understand that trainees, under appropriate supervision, may perform or observe some of the health care services that I receive. Additionally, I understand that students may perform certain services under appropriate supervision.

PERSONAL VALUABLES: I understand that Concord Hospital is not responsible for my personal possessions. If I choose to keep personal belongings during my hospital stay, I may request that these items be stored in the hospital safe.

RECEIPT OF PATIENT INFORMATION: I acknowledge that I have been offered and/or provided a copy of the Patients' Bill of Rights.

ASSIGNMENT OF BENEFITS AND PAYMENT TERMS: I agree to assign to Concord Hospital, all insurance benefits otherwise payable to or on behalf of the undersigned for the services rendered. I agree that I am responsible to pay the balance owed if the insurance or personal information I have given is not true. I understand that I remain liable for all charges not covered by insurance or other benefits. I agree to pay Concord Hospital in accordance with its regular rates and terms for all services rendered.

I agree to assign to my treating providers all insurance benefits otherwise payable for the services rendered and agree that I will be responsible for any amount not covered. I grant permission to my treating providers to release my medical records for the purpose of claims adjudication.

Pursuant to NH RSA 151:12b when billing SELF-PAY patients, Concord Hospital accepts as payment in full an amount no greater than the amount generally billed and received by health carriers in a manner consistent with Section 9007 of the Patient Protection and Affordable Care Act of 2009. As such, uninsured patients will receive a discount off charges at the time of billing. Self-Pay Rates do not apply to insured patients for copayments, coinsurance, deductibles, or non-covered services.

All amounts are due immediately, upon receipt of the bill for said services. In the event that the bill is not paid pursuant to these terms and the account is placed with an attorney or agency for collection, I agree to pay actual attorney's fees and cost of collection.

I understand that if I am presenting with a work-related injury, it is my responsibility to provide Concord Hospital with accurate information regarding my employer and my workers' compensation insurance. I further understand that I remain liable for all charges not covered by workers' compensation, health insurance, or other benefits.

PHONE COMMUNICATION: I consent to receive calls to the cellular and residential telephone numbers I have provided, including calls using any type of artificial or prerecorded voice or auto-dialer technologies made by or on behalf of the Hospital, its providers, assignees, agents, servicers, debt collectors, or any owner of a receivable for unpaid services or treatment provided to me by the Hospital or any of its providers.

NON-EMPLOYED PROVIDERS: I understand and acknowledge that many of the providers on the Concord Hospital medical staff are not employees or agents of Concord Hospital, included but not limited to, specialists who provide services in anesthesiology, orthopedics, radiology, pathology, and emergency care. These independent contractors/treating providers have been granted the privilege of using the Concord Hospital facilities for care and treatment of their patients. I understand and acknowledge that Concord Hospital cannot be held legally responsible or liable for the conduct of these providers. I further understand that I will be billed separately for the services provided by these providers.

By signing below I acknowledge that I understand and agree to the terms set forth above.

______________________________ ______________________________
Patient/Legal Guardian/Appropriate Authorizing Party   Witness signature

____
Date/Time

____
Print name and relationship to patient
Patient is unable to personally authorize because: ______________________________