HOSPITAL FOR SPECIAL SURGERY

GENERAL CONSENT/ PERMISSION FOR TREATMENT
FINANCIAL AGREEMENT
(OUTPATIENT)

I authorize and consent to performance upon _____
(***Insert "me" or Name of Patient***)
by Hospital for Special Surgery (HSS) and its staff of such physical examinations, diagnostic imaging procedures (such as x-rays, CT scans, and/or magnetic resonance imaging (MRI)), laboratory tests, and other non-invasive diagnostic and therapeutic procedures and/or treatments, as my/the patient's physician or others on HSS's medical staff consider to be necessary or appropriate for the purpose of diagnostic and/or treatment of my/the patient's condition.

I understand that for each procedure/treatment the following will be explained to and discussed with me/the patient: the nature, intended purpose, anticipated benefits, material risks, and possible complications of such procedure/treatment; the alternative procedures/treatments if such procedure/treatment is not performed; and the probable consequences if such procedure/treatment or alternative procedures/treatments are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure/treatment may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I consent to the diagnostic study by HSS of any blood, urine or other bodily fluids, stool specimens, or tissues that are obtained in the performance of such procedures/treatments, and to the disposal of such fluids/ specimens/tissues by HSS in accordance with its customary practice. I further grant permission for HSS to use such fluids/specimens/tissues for medical, scientific and/or educational purposes.

I consent to the photographing, videotaping, televising, or other observation of the procedures/treatments as HSS or its surgeon(s)/physician(s) may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedures/treatments of a visitor or visitors, which may include any visiting physician(s) and/or vendor representative(s) whose presence has been requested by the above named surgeon(s)/ physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other HSS personnel, and subject to all relevant HSS policies and procedures.

I understand that information about me/the patient will be disclosed as required by applicable law, including reporting mandated by the federal, state and local governments to oversight agencies such as Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene. Examples of such mandated reporting include reporting of suspected or confirmed communicable diseases, child abuse, firearm wounds, and certain knife wounds and burns.

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I understand that HSS does not provide all of the medical services that I/the patient could ever possibly require, and that in the event I/the patient need treatment not provided by HSS during my/the patient's hospitalization at HSS, it may become necessary to transfer me/the patient to another hospital that provides the medical services required by me/the patient (including, for patients at HSS's main campus, New York-Presbyterian Hospital). I hereby consent to the transfer to such other hospital of me/the patient for such treatment when HSS determines that transfer is medically necessary or advisable. HSS 0827A (02/16) OUTPATIENT

I understand that HSS will electronically transmit prescriptions to my pharmacy (ePrescribing) as required by New York law. I also understand that in connection with ePrescribing, HSS and members of its Medical Staff will obtain medication history (information about the medications I/the patient are currently taking or have taken within the past year) for purposes of coordinating my/the patient's treatment. I hereby consent to ePrescribing by HSS and members of its Medical Staff, including obtaining my medication history and making it part of the HSS medical record.

FINANCIAL AGREEMENT

Assignment of Benefits

I assign, transfer and set over to HSS and members of its Medical Staff sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient by HSS and its Medical Staff.

If I am entitled to Medicare benefits, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services; 20% co-insurance on all ancillary services. I also understand that when Medicare is deemed that secondary insurance responsible for payment of my medical care, I will be financially classified under HSS's policies and will follow payment terms under said policies.

Authorization for Release of Information

I authorize and direct HSS and those members of its Medical Staff who have treated me/the above-named patient to release to government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient, all information needed to substantiate and obtain payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Guarantee of Hospital Charges

I agree to be responsible for payment in full of the charges for all hospital services and other medical care rendered to me/the above-named patient for this period of care. I understand that even if I have/the patient has domestic or international health insurance coverage accepted by HSS, I will be

responsible for payment in full of unpaid balances after insurance company payment to HSS, to the full extent permitted under federal, state and local laws. I understand that my responsibility also includes payment for charges not ordinarily covered by health insurance, such as private room charges.

I confirm that I have read and fully understand this General Consent/Permission for Treatment & Financial Agreement, that I have been given the opportunity to ask questions and have had my questions answered satisfactorily, and that I am eligible to give this consent and agreement. I further confirm that I understand that I have the right to revoke this consent, or any part of it, at any time during my/the patient's treatment by HSS.

Signature of Patient/Parent/Guardian/ _____ Date_____
Health Care Agent/Other Surrogate
Relationship to Patient _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this General Consent/Permission for Treatment & Financial Agreement.

Signature of Witness _____

Date Time _____