Ascension Wisconsin* Consent for Treatment and Financial Agreement

GENERAL CONSENT TO CARE

* I am coming for care and treatment. I agree to services including examinations, procedures, x-ray and lab services, tests and treatments, medication, monitoring, nursing care, counseling and education.
* I understand that some of the doctors and staff caring for me are not employed by the organization and the organization is not liable for any act or omission of such providers.
* I understand that if tissue or body parts are removed when I am in the hospital, the hospital or pathologists may use or dispose of the tissue or body parts at their discretion unless I disagree.
* I understand that electronic communication such as telemedicine may be used to help healthcare providers at different locations to participate in my care.
* I understand that some facilities participate in education and training programs and that I may receive healthcare services performed or observed by students/ trainees.
* I understand that the provision of healthcare is not an exact science and I acknowledge that no guarantees have been made to me as a result of examinations or treatments provided to me.

HOME HEALTH, MEDICAL EQUIPMENT

* In order to facilitate informed decisions about services available upon my discharge, I agree to have post-discharge care providers, including but not limited to home health agencies, involved in my discharge planning process.
* I understand my health information may be shared with post-discharge care providers to create a discharge plan for me. I understand that I am not obligated to select these providers or the services they offer.
* I understand that information about post-discharge care provider options will be provided to me should the need arise and it is my choice as to which provider I might use.

IMPORTANT INFORMATION

* I know that I need to follow up with recommended care after I am discharged.
* I agree to notify the hospital or my doctor within 24 – 48 hours if am canceling or rescheduling an appointment.
* I know that the facility may take pictures or video of me for my care and safety.
* If I have a baby, I agree for my baby to have pictures taken for security reasons.

ACCESS TO HEALTHCARE RECORDS

* I know that I may review my medical record during normal business hours upon reasonable notice.
* I know that I may get a copy of my medical record and I may be asked to pay for the copies.

VALUABLES (Hospitals only)

* I know I should not keep valuables such as money, jewelry, important papers, or dentures with me.
* I know that the facility has a safe place where valuables may be stored.
* I know that I keep my items at my own risk. I agree that the facility may not be liable for any loss or damage to valuables that I keep with me.

RELEASE OF INFORMATION FOR BILLING PURPOSES

I agree that the facility and all healthcare providers participating in my treatment may release my health information to my insurers and other payers or other persons as necessary for billing, collection or payment of claims for services provided.

ASSIGNMENT & FINANCIAL AGREEMENT

* I assign to the facility or healthcare provider any payment for such services otherwise payable to me under a benefit plan through Medicare, Medicaid, an insurance carrier(s), an employer health plan(s) or any other third party payer(s) (each referred to as a "Plan").
* I allow my Plan (s) to send all payment directly to the billing facility or healthcare provider.
* Ascension Wisconsin will try to verify my Plan(s) coverage for services and obtain any approvals and authorization required by my Plan and shall notify me of any services it knows are not covered by the Plan.
* I understand that should my Plan deny payment for the services provided to me, I am ultimately responsible for paying the charges billed for the services, including co-pays, co-insurance, and deductibles charges consistent with any applicable, written contractual agreements between Ascension Wisconsin and my Plan and Ascension Wisconsin's patient financial assistance policies. I agree to cooperate with Ascension Wisconsin on any appeals of my payer's denials and authorize Ascension Wisconsin to be my representative on these appeals.
* I agree not to revoke this assignment and authorization without the facility's or healthcare provider's consent. If I receive payment directly from my Plan, it is my responsibility to forward it to Ascension Wisconsin within 30 days of receipt.
* I know that I am responsible for knowing the limitations of my Plan's benefit coverage. If my Plan determines that a service is not a covered benefit under the Plan or is experimental or investigational, I will be responsible for paying the charges billed by the facility or healthcare provider for the service. Ascension Wisconsin reserves the right to balance the bill for any services in which a payment is made by a Non-Network plan (i.e., there is no written contract between Ascension and patient's employer). I further acknowledge that, should the amount covered by my Plan(s) benefits be insufficient to cover the charges for the services rendered to me, I will be responsible for the payment of the difference.
* I agree that credit balances resulting from payments made by the patient or other sources may be applied to any account owed to the facility or healthcare provider by the same guarantor (me or my family).
* I understand that I may request an estimate of certain treatment costs prior to receipt of treatment by following directions posted online at the Ascension website healthcare.ascension.org.
* I understand Ascension offers a financial assistance program for patients who may not be able to pay for all of their medical expenses or need additional time to pay. If you would like more information, you are encouraged to contact the facility business office or on-line at healthcare.ascension.org.
* I understand that I should also expect to receive invoices from other healthcare providers who provided care to me, such as anesthesia, pathology and radiology which are billed separately from the facility.

COLLECTION & ASSIGNMENT

Should my account or any unpaid portion thereof be referred to an attorney for collection, I agree that I shall also be responsible for all reasonable attorney fees, including Ascension Wisconsin's attorney fees and personal attorney fees, and any other costs, fees or expenses incurred as a result of the collection process as allowed by Wisconsin law.

PATIENT'S CERTIFICATION/PAYMENT REQUEST

Patient's Certification/Payment Request under Title XVIII and Title XIX or the Social Security Act (Medicare/Medicaid): I certify that the information given by me in applying for payment under the Title XVIII and Title XIX of the Social Security Act and Wisconsin's Medicaid Assistance law is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. As a Medicare inpatient, I acknowledge that I have received a copy of the "Important Message from Medicare/TRICARE." This authorization extends to the time when this or a related claim is paid or is finally denied. I request that payment of authorized benefits be made on my behalf.

PRIVACY NOTICE AND PATIENT RIGHTS

* I confirm that I received or was offered and declined a copy of the Notice of Privacy Practices. I know I can get more information about the uses of my medical record from that notice.
* I confirm that I received or was offered and declined a summary of the organization's financial assistance program.
* I confirm that I received or was offered and declined a copy of the Patient Rights and Responsibilities.
* I agree to let the facility or provider release information to other healthcare providers and school health offices through the Immunization Registry in the State of the Facility or provider.

ETHICAL & RELIGIOUS DIRECTIVES

I acknowledge that Ascension Wisconsin is a Catholic organization and provides all care in compliance with the Ethical and Religious Directives for Catholic Healthcare and that some services may not be provided at Ascension Wisconsin facilities.

TELEPHONE CONSUMER PROTECTION ACT

I agree for Ascension Wisconsin, its providers and agents, including debt collectors, to place calls to my cellular and/or residential phone using artificial or pre-recorded voice or auto-dialer technologies for any permissible purpose, including debt collections and/or account verification.

DOCUMENT CHANGES

I know that if I make any changes to this form prior to non-emergent services performed it may keep me from getting the care and services.

DOCUMENT ACKNOWLEDGEMENT AND DURATION

* My signature indicates that I have read and understand the Consent to Treatment and Financial Agreement form.
* I understand that this agreement applies to all Ascension Wisconsin facilities.

Patient Signature	Date (m/d/y)	Time	Witness Signature	Date (m/d/y)	Time
Person signing on patient/s behalf	Date (m/d/y)	Time	Relationship to patient		
Signature of Face to Face Interpreter - OR Signature of Designated Interpreter (per waiver) - OR Phone or Video Interpreter ID#	Printed Name/Affiliation	Date/Time			

Ascension Wisconsin complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-462-4973. LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-462-4973.

Ascension Wisconsin refers to all healthcare organizations wholly owned, controlled and/or managed indirectly or directly by Columbia St. Mary's, Inc., Ministry Health Care, Inc. or Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc. or their successor organizations.