

**Mary Washington Healthcare
General Consent for Treatment**

Coverage

This form covers all services or goods provided or to be provided by Mary Washington Healthcare (or its subsidiaries or affiliates). In addition, this form covers all services or goods provided to the patient by any healthcare provider rendering care to the patient while the patient is receiving services or goods from MWHC.

Consent for Examination and Treatment

I have a condition requiring inpatient or outpatient care and I voluntarily consent to such care, including diagnostic and laboratory procedures and medical treatment by my physician and hospital personnel. I understand that the practice of medicine and surgery is not an exact science and I know that treatment results cannot be guaranteed. I understand that the majority of the physicians or physician extenders providing services to me are not employees of MWHC, but are independent practitioners providing professional services. I understand that MWHC participates with healthcare education programs and students may be involved in my care. I agree that MWHC and my physician may obtain specimens and tissues as appropriate for my diagnosis and treatment and their respective health care operations, and I hereby authorize MWHC to dispose of any specimens or tissues taken from my body. I consent to video or the use of other electronic monitoring or recording method necessary for my treatment or safety. I understand that MWHC is not able to prepare certain compounded medications. In the event that I need compounded medications that MWHC is not able to prepare, I consent to receive compounded medications prepared by non-MWHC pharmacies.

Deemed Consent

I have a condition requiring inpatient or outpatient care and I voluntarily consent to such care, including diagnostic and laboratory procedures and medical treatment by my physician and hospital personnel. I understand that the practice of medicine and surgery is not an exact science and I know that treatment results cannot be guaranteed. I understand that the majority of the physicians or physician extenders providing services to me are not employees of MWHC, but are independent practitioners providing professional services. I understand that MWHC participates with healthcare education programs and students may be involved in my care. I agree that MWHC and my physician may obtain specimens and tissues as appropriate for my diagnosis and treatment and their respective health care operations, and I hereby authorize MWHC to dispose of any specimens or tissues taken from my body. I consent to video or the use of other electronic monitoring or recording method necessary for my treatment or safety. I understand that MWHC is not able to prepare certain compounded medications. In the event that I need compounded medications that MWHC is not able to prepare, I consent to receive compounded medications prepared by non-MWHC pharmacies.

Patient Rights, Grievance Process, Advance Directives

I have reviewed a copy of my rights and responsibilities as a patient. I understand that MWHC has a formal process to address and resolve any concerns or grievances as detailed in the Patient Rights and Responsibilities Form. I understand that, under Virginia law, I have the right

to determine in advance, or to choose in advance someone to determine for me, what kind of medical or surgical treatment I would want if I am incapable of communicating to my doctor what kind of treatment I wanted, or if I am incapable of making an informed decision about my care. I acknowledge that the Hospital has provided me or has offered to provide me “Your Right to Decide” regarding these “advance directives.” If I already have an advance directive, I will provide a copy to be placed in my medical record and understand that the Hospital cannot follow the directives of my Advance Directive until I do provide it or draft a new one. If I do not already have an advance directive, I may request more information from my nurse or physician.

Personal Valuables

I assume full responsibility for all of my personal items, including, but not limited to, my clothing, money, jewelry, glasses, dentures, hearing aids or other personal items and release MWHC from responsibility and liability for such personal items and valuables.

Business Communications

I authorize MWHC to contact me after discharge for performance improvement purposes such as conducting patient satisfaction surveys. Further, by providing the hospital with my cellular or wireless telephone number, I authorize the use of an automatic telephone dialing system to contact my cellular or wireless telephone for normal business communications such as appointment reminders or collection efforts.

Joint Notice of Privacy Practices

I understand that MWHC may use and disclose my protected health information for purposes of treatment, payment and operations. I also acknowledge that I have reviewed, have been offered, or have reviewed in the past a copy of the Joint Notice of Privacy Practices for MWHC which provides information about how MWHC and individuals involved in my care at MWHC may use and disclose my protected health information.

Mary Washington Healthcare

Guaranty of Payment

Responsibility for Payment

In consideration of the services provided at MWHC, I understand and acknowledge that: (1) I am financially responsible for the charges for all goods and services provided to the patient that are not covered by third party payor; (2) at all times, I shall have the responsibility to determine and to meet the requirements of any third party payor; (3) where MWHC or any health care providers may provide advice and assistance to the patient, such advice and assistance shall not relieve me of the responsibility to determine and to meet the requirements of any third party payor; (4) I shall not assert any claim that I was relieved of this responsibility in the absence of an express written agreement to the contrary; and (5) In the event litigation is filed for nonpayment for charges, I agree to pay all expenses incurred by MWHC or any health care provider because of such litigation, including reasonable attorney’s fees and medical expert witness fees.

Assignment of Benefits

I hereby assign to MWHC, my physician(s) and other healthcare professional(s) involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, Workers Compensation or any other programs that I identify for which benefits may be available to pay for the Hospital and medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

Third-Party Providers

: I understand that certain professional services may be rendered during my hospital stay by third-party health care providers (such as ambulance services, emergency physicians, radiologists, pathologists, anesthesiologists) that are not covered by my insurance or plan. I also understand that some of the third-party health care providers who render care to me during my stay may not be participating providers with my health insurance company or benefit plan. In either instance, I agree that I will be financially responsible to these third-party health care providers for their charges in performing these professional services.

Financial Assistance

If I am uninsured or am having difficulty paying my Hospital bill, I understand the Hospital has many financial options that may be of assistance, including free care, discounted care or interest-free payment plans. I understand that I will be required to provide financial information to determine my eligibility for these programs. The Hospital's financial counselors can help me apply for these programs. Financial counselors can be reached toll free at (540) 741-3555 or 1-800-344-4198.

Authorization for Verification of Information

I hereby authorize MWHC to obtain and release my information for the purpose of verifying any information that I have provided to MWHC or that another individual has provided to MWHC on my behalf (including credit and employment information).

Certifications

I certify that I have read this entire form, that I was given a chance to ask any questions I had about this form, that all of my questions about this form have been answered to my satisfaction, and that I understand the content and purpose of the form. I acknowledge that I have received a copy of this form.

I certify that I am the patient, or that I am a person authorized by the patient and/or in accordance with Virginia law to sign this form and accept its terms. I certify that the information provided and to be provided to MWHC and all healthcare providers is and will be true and correct. I agree to pay any expenses incurred by MWHC and all health care providers because of incorrect information provided by me. I further acknowledge that, should I provide false or fraudulent information relative to the services provided, the Hospital may contact law enforcement to initiate civil and/or criminal proceedings.

Mary Washington Healthcare
PATIENT'S RIGHTS AND RESPONSIBILITIES

At Mary Washington Hospital, we are committed to providing our patients with the best possible health care. We believe that patients who understand and participate in their care may achieve better results. We encourage you to become an active partner with your health care team by being informed about your rights and responsibilities as a patient. We will do our best to honor these rights to the best of our ability, while providing appropriate and safe care to all of our patients.

As a patient, surrogate, or guardian, you have the **right** to:

- Considerate, respectful, safe and quality health care.
- Information in your language and with aids or assistance as needed about your medical status, diagnosis, prognosis, and plan of treatment.
- Active involvement in your plan of care, including the right to consent to or refuse treatment and to be informed of the consequences of your actions.
- have your pain assessed and treated appropriately.
- Designate a representative or medical power of attorney and have that person included in your plan of care.
- Have a family member or representative of your choice or your own physician notified promptly of your admission to the Hospital.
- Identification of all health professionals participating in your care.
- Freedom from mental, physical, sexual, and verbal abuse, neglect, and exploitation.
- Freedom from any form of restraints that are not medically necessary.
- Safe care, and to be told if something goes wrong with your care.
- Freedom from discrimination, and to have your cultural, psychosocial, spiritual and personal values, beliefs, and preferences respected.
- Privacy, confidentiality (including the confidentiality of your clinical records), and respect for your personal dignity.
- Request information about business relationships between Mary Washington Hospital, its affiliates, and other health care providers.
- Consent or decline to participate in proposed research studies.
- Request consultation to assist in the resolution of ethical dilemmas.
- Receive information about charges for which you will be responsible.
- Get an up-to-date list of all of your current medications at discharge.
- Financial assistance with the cost of your health care if you qualify.

As a patient, parent, surrogate, or guardian, you have the **right** to:

- Receive information about any restrictions on visitation.
- Receive visitors of your choosing.
- Have visitors unless visitation would interfere with your care or the care of others.

As a patient, parent, surrogate, or guardian, you have the **responsibility** to:

- Provide complete and accurate personal identifying information.
- Provide all necessary personal and medical history required for your treatment.
- Provide the hospital with your current Advance Medical Directive.
- Be considerate and respectful of members of the health care team, and to accommodate the legitimate needs of the hospital, other patients, medical staff, and hospital employees.

- Ask if you do not understand your illness or proposed plan of treatment.
- Follow your treatment plan, tell your physician if you are not willing or able to do so, and accept the consequences of your action.
- Participate in continued care after discharge from the hospital and keep follow-up appointments.
- Provide the information necessary to process your medical insurance, and make financial arrangements regarding your hospital bill.
- Be responsible for the safekeeping of clothing, money, and personal items you choose to keep with you.
- Follow the rules and regulations of the hospital.

We are pleased to address any questions or concerns you may have about these rights and responsibilities, your hospitalization, or the care provided to you. The hospital has a formal process to address and resolve any concerns, complaints, or grievances. If you have a complaint or concern about patient care or safety, or other aspects of your hospitalization or treatment, we recommend that you first attempt to resolve any issues with the care center in which the problem occurred. **If these attempts are unsatisfactory, or if you are not comfortable doing so, you may call 540-741-3955 for assistance in addressing and resolving these issues.** Alternately, you may call the Virginia Department of Health, Office of Licensure and Certification or the Joint Commission's Office of Quality Monitoring, directly whether or not you have first spoken with, or used the Hospital Grievance process. The address and phone number of the Office of Licensure and Certification is 9960 Maryland Drive, Suite 401, Richmond, Virginia 23233-1463; 800-955-1819. The telephone number of the Joint Commission's Office of Quality Monitoring is 800-994-6610.

Snowden at Fredericksburg.

If your issue is related to Human Rights and you choose not to use the avenue noted above, you may contact the Regional Human Rights Advocate, Kevin Paluszak at 703-323-2098 or 1-877-600-7431.

Concerns regarding care at Snowden at Fredericksburg may also be made to the Department of Behavioral Health and Development Services, Office of Licensure and Certification at 804-786-3921.

If you feel you have been wrongly denied admission to a Snowden at Fredericksburg program, you are entitled to an impartial review by the Administrator within 7 days of the denial.