Hackensack Meridian
Mountainside Medical Center

GENERAL ADMISSION CONSENT FOR CARE AND ACKNOWLEDGEMENT OF RECEIVING INFORMATION

GENERAL CONSENT FOR CARE

I authorize Mountainside Medical Center ("Medical Center"), hospital staff and the physician(s) participating in my care, to render care for my condition as may be deemed advisable by the physician(s), which may include diagnostic procedures and routine hospital care such as IV insertions and intramuscular injections. I understand that no guarantees have been made to me regarding the outcome of this care or my condition. If I am admitted to deliver a baby then this consent shall also apply to the admission and hospital treatment of the infant(s) who is/are delivered by me during the hospitalization.

INDEPENDENT PHYSICIANS

I understand that most of the physicians who will participate in my care and treatment are NOT employees, agents or servants of the Medical Center. This includes physicians who are assigned to my care and whom I have not independently selected. Examples of the physicians who may be assigned to my care but are NOT employees, agents or servants of the Medical Center include, but are not limited to: Emergency Department Physicians, Anesthesiologists, Radiologists, Laboratory Services (Pathologists), Radiation Oncologists, Neonatologists, Psychiatrists, Intensivists, and Hospitalists. I further understand and agree that the Medical Center is not responsible for the judgement or conduct of these physicians providing medical services at the hospital.

I understand that the fees charged by the Medical Center do not include the fees charged by my treating physician(s). I understand that I will be billed directly by my treating physician(s). I understand that it is my responsibility, and NOT the responsibility of the Medical Center, to determine the extent of my insurance coverage for treatment proposed or render by any physician(s) at the Medical Center.

RELEASE OF PROTECTED HEALTH INFORMATION

I understand that my medical records will be maintained in the Epic Electronic Health Records ("EHR") system. I understand and agree that my information may be accessed by another facility or provider who participates in our EHR system for purposes of my treatment, as well as for purposes of system operations and management, and evaluating and improving patient care.

I have received and read a copy of the Notice of Privacy Practices for Protected Health Information ("the Notice"). This Notice provides a description of the Medical Center's potential uses and disclosures of my Protected Health Information ("PHI"). I authorize the Medical Center and/or any physician(s) participating in my care to release my PHI (either in writing or verbally) for the purposes of my continuing care to any person, corporation and/or government agency that is or may be responsible to satisfy all or part of the Medical Center's charges or who may be required to pre-certify or verify admission and/or treatment. I authorize the Medical Center to verify my address through the Federal Credit Reporting System and I understand that the Medical Center may be required to release my PHI to federal and state agencies that monitor healthcare facilities. I consent to the Medical Center's release of my name, general condition and room telephone number when requested.

I understand that the Medical Center participates in Jersey Health Connect and I consent to the Medical Center sharing my PHI with Jersey Health Connect. I understand that Jersey Health Connect is a Health Information Exchange (HIE) that allows the Medical Center to share my health information among participating providers including, but not limited to, physicians, hospitals, labs, radiology centers, and other healthcare providers through secure, electronic means. I understand that the purpose of the HIE is to allow my healthcare providers to have access to the most recent information available in order to facilitate my care. I understand that I may not wish to participate in Jersey Health Connect and that I may opt out at any time by completing one of the following steps:

- Call toll free: 1-609-945-1183
- Go to www.jerseyhealthconnect.org/patient/opt-out/ and print off your opt-out form. Then mail your completed opt-out form to the following address:
  Jersey Health Connect
  P.O. BOX 261
  Oldwick, NJ 08858
- Fax a completed opt-out form to: 1-609-945-5315

PRECERTIFICATION REQUIREMENTS

I understand and agree that if I do not comply with my insurance coverage pre-certification requirements or if any service is not certified, then I may not be entitled to insurance benefits, and in that event, I will be responsible for any and all Medical Center charges at its standard rates.

ASSIGNMENT OF BENEFITS

I hereby certify that the information given to the Medical Center regarding my health insurance and/or other form of health benefits, and the information provided regarding the coordination of my benefits (if I hold coverage under more than one policy) is accurate and current to the best of my knowledge

I hereby designate the Medical Center as my authorized agent in all matters arising under a claim for benefits from any coverage source for any and all medical care provided to me and for all related expenses incurred. I therefore assign to the Medical Center all of my rights, benefits, privileges, protections, claims, causes of action, interests of recovery, to any and all rights, benefits, privileges, protections, claims, causes of action, interests, or recovery of any type whatsoever receivable by me or on my behalf arising out of any policy of insurance, plan, trust, fund, or otherwise providing healthcare coverage of any type to me (or to any third party responsible for me for the charges for services rendered to me by the Medical Center. This includes, without limitation, any private or group health/hospitalization plan, automobile liability, general liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits, settlements/judgments/verdicts, self-funded plan, trust, workers compensation, MEWA, collective, or any other third-party payer providing healthcare coverage of any type to me (or to another third party responsible for me) for the charges for services rendered to me by the Medical Center (collectively, "coverage source"). This is a direct assignment to the Medical Center of any and all of my rights to receive benefits arising out of any coverage source. I understand that this assignment of benefits is irrevocable. This assignment of benefits fully and completely encompasses any legal claim I may have against any coverage source, including, but not limited to, my rights to appeal any denial of benefits on my behalf, to request and obtain plan documents, to pursue legal action against any coverage source, and/or to file a complaint with the state department of banking and insurance.

FINANCIAL AGREEMENT

I hereby authorize and direct that payment of all benefits, payments, monies, checks, funds, wire transfers or recovery of any kind whatsoever from any coverage source be made to the Medical Center and I agree to assist the Medical Center in pursuing such payments from any coverage source. This includes without limitation, signing documents as required to pursue claims and appeals, obtaining document/information from the coverage source, or otherwise to support payment to the Medical Center. I further agree that any payments of any kind for services provided by the Medical Center that is received by me (or received by any other third party responsible for me) will be turned over immediately to the Medical Center, through whatever means necessary. This includes, without limitation, me, and if needed any guardian, endorsing any checks and/or other documents to the Medical Center. I also understand that if I fail to turn over to the Medical Center any such payments received by me (or by a third party responsible for me), I will be financially responsible to the Medical Center for the full amount of such payments, and I may be subject to civil or criminal prosecution to the fullest extent of the law.

If monies paid by me or on my behalf result in a credit balance in my favor I authorize and direct that the Medical Center apply such monies toward any unpaid balance owing and due by me on any accounts held by the Medical Center or by any of our affiliated entities, inclusive of both facilities and clinicians. I understand that my current or future care is not dependent upon this authorization, and that if in the future I wish to dispute my obligation on any account and do not want that account to be subject to transfer of funds that I must expressly and unequivocally communicate that position to the Medical Center and/or affiliate in a timely manner.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. I understand that if the Medical Center or any of its affiliates are out-of-network with my insurance plan, then my financial responsibility may include: (1) higher coinsurance and deductible amounts; and (2) the Medical Center's full charges, including the amount that exceeds the allowable charges of an in-network preferred provider.

I understand that I am financially and legally responsible for charges not covered in full by the assignment of benefits described

in the preceding sections, including, but not limited to, any deductibles, copayments, and coinsurance amounts provided under any coverage source; and charges for which there is no coverage source. I further agree that should I not pay any balance for which I am legally responsible as set forth in this section within thirty (30) days after the date of discharge, my account will be considered delinquent. I agree to pay any costs incurred by the Medical Center to collection any delinquent amounts, including reasonable attorney's fees and costs, collection agency fees and costs, and interest which shall accrue at the maximum rate allowed by law. The undersigned acknowledges understanding and agrees that a credit balance of $24.99 and less will not automatically be refunded but shall only be refunded upon explicit request.

MEDICARE PAYMENT REQUEST

I certify that the information given by me in applying for payment under Tile XVIII of the Social Security Act 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 claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services or authorize a physician or organization to submit a claim to Medicare for payment.

I understand that services received by me may not be covered by my MEDICARE insurance and that in such event I will be responsible for all charges not covered. I have received "NOTIFICATION OF OUTPATIENT/OBSERVATION SERVICES" and I understand my rights as outlined in this document.

I understand that this consent shall operate as a complete release of liability in favor of the Medical Center, it's agents, servants and employees and my physician(s) for the release of information as stated above.

CONSENT TO CONTACT

TELEPHONE CONSUMER PROTECTION ACT CONSENT DISCLOSURE - Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications.

By providing my telephone number (whether landline or wireless) and/or email address to the Medical Center, I expressly consent that the Medical Center and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to the Medical Center or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or the Medical Center's services, including, but not limited to the following: my hospitalization or treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of the Medical Center and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from the Medical Center. I understand that I will be able to change my preference at any time. This can be done via your MyChart account under Your Menu, then Accounting Settings, then Personal Information, or by contacting patient access/registration or your physician's office.

AUTHORIZATION FOR THE PRESENCE OF OTHERS DURING TREATMENT

I hereby authorize physicians-in-training, medical students nursing students to observe and participate in my care under the supervision of the Medical Center staff and my physician(s). Furthermore, I understand that my physician(s) may require the assistance of consultants, and I authorize these consultants to participate in my care as appropriate. Additionally, I authorize vendors or other observers to be present during treatment and procedures.

PHOTOGRAPHY

I hereby authorize the use of photography during my routine care, if ordered by my physician for the purposes of documenting treatment, diagnosis, condition identification and/or response to treatment.

AUTHORIZATION FOR SPECIFIC BLOOD TESTING

I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I acknowledge that I have received an explanation of the HIV and Hepatitis B and C infections and meanings of the possible test results. I have been given the opportunity to ask questions and I understand that declining testing will not affect my care. I understand and agree that the results of the blood test(s) will be released to me and to any qualified personnel directly involved in my diagnosis or treatment. If test results are positive for HIV, the results will also be provided to the New Jersey Department of Health and Senior Services as required by law. I authorize my test results to be provided to the Medical Center Occupational Medicine Service and to any healthcare provider (including a student, volunteer or physician) or first responder (including an emergency medical service worker or police officer) exposed to my blood or bodily fluids that makes a request for testing and the results of such testing. To the extent possible, these results will be provided to the healthcare provider or first responder without disclosing my name. I understand that in addition to the information provided to me concerning HIV and Hepatitis B and C, additional information and counseling are available through my physician.

PERSONAL VALUABLES

I understand that the Medical Center is not responsible for the loss of or damage to any personal property. I acknowledge that personal property such as electronic equipment, money and jewelry should be sent home with family and friends. I accept full responsibility for any personal property that I elect to keep in my possession.

DEPOSIT REQUEST

A deposit has been requested of me because I will be paying for all and/or part of the hospital bill. I understand that the hospital's acceptance of partial payment does not relieve me of my responsibility for the full amount.

ACKNOWLEDGMENT OF MATERIALS RECEIVED

I acknowledge that I have been provided with information and/or have received informational materials regarding the following topics:

1. New Jersey Patient Bill of Rights;
2. Advanced Directives Brochure;

I have read this form in its entirety, all of my questions have been answered, I understand the content of this form and agree to all of its content.

Signature of Patient	Date and Time
Signature of Person Signing on Behalf of Patient	Date and Time
Printed Name of Person Signing on Behalf of Patient	Relationship
Reason Patient Is Unable to Sign	
Signature of Witness (Hospital Employee)	Date and Time