MedStar Health

(Place patient ID sticker here)

# Entity general consent form

**Healthcare entity: check the applicable box**

- ❑ MedStar Franklin Square Medical Center
- ❑ MedStar Georgetown University Hospital
- ❑ MedStar Good Samaritan Hospital
- ❑ MedStar Harbor Hospital
- ❑ MedStar Montgomery Medical Center
- ❑ MedStar National Rehabilitation Hospital
- ❑ MedStar Southern Maryland Hospital Center
- ❑ MedStar St. Mary's Hospital
- ❑ MedStar Union Memorial Hospital
- ❑ MedStar Washington Hospital Center
- ❑ MedStar Ambulatory Surgery
- ❑ MedStar Health Home Care
- ❑ MedStar Health Physical Therapy: _____ (location)
- ❑ MedStar Medical Group: _____ (location)
- ❑ MedStar Health Urgent Care: _____ (location)

---

**What Is This Consent For?** I understand that I am allowing my care team, including clinical providers of the MedStar healthcare entity indicated above, to examine, treat and otherwise care for me. I am also allowing resident physicians, medical students and/or other health professionals in-training to observe or participate in my care under proper supervision.

- I understand that I may always refuse any treatment, test, or procedure.
- I understand that I may always ask questions about my treatment or condition.
- I understand that clinical photography/recording may be included with my treatment.
- I understand and permit a blood sample to be drawn to test for any infection which could be passed on to my care team if the care team member is exposed to my blood or other bodily fluid.
- I understand that if I need a procedure or want to join a research study, I will have to complete another consent form that is for the procedure or study.
- I understand that not all clinical providers are employees, servants, or agents of the MedStar healthcare entity indicated above. Rather, some are independent contractors who have been granted the privilege of using a MedStar facility.
- I understand that if it is important to me to know whether my clinical provider is an employee of the MedStar healthcare entity indicated above, I may inquire about their status.
- I understand that the MedStar healthcare entity indicated above is not liable for the care and treatment of these independently contracted clinical providers.

**About My Financial Responsibilities.** I understand that I am financially responsible for my bill in the event my insurance does not pay in its entirety or I am uninsured. I will be appropriately charged even if I leave before my visit is complete.

- **"Assignments of Benefits."** I understand and authorize any insurance payments (whether Medicare, Medicaid, or any other company) to be made directly to the MedStar healthcare entity indicated above and applied to my bill.
- **Provider Charges.** I understand I may also receive separate bills from the provider(s) involved in my care.
- **My Ability to Pay.** I understand that payment plans are available based on my financial needs.
- Financial Assistance is also available for those that qualify for free or reduced care.
- If my bill goes to collections, I understand that I may also be responsible for those fees if a judgment is obtained.
- I authorize the MedStar healthcare entity indicated above to contact me by phone, cell phone, mail, and/or email.

**About My Personal Information.** I understand that the MedStar healthcare entity indicated above may release my final diagnosis and other medical information for the purpose of continuing my treatment, determining any payment, or assisting business operations.

**About My Valuables.** I understand that the MedStar healthcare entity indicated above is not responsible for any loss or damage to my property. I have been advised that if possible, I should leave all money and valuables at home or with a friend or family member.

**This form needs to be signed at each ED and inpatient occurrence and annually for outpatient visits.**

**I have also received the following papers, and they have been explained to me.**

- Patient Rights and Responsibilities _____ Initials
- Notice of Privacy Practices _____ Initials
- Notice of the Financial Assistance Policy _____ Initials
- An Important Message from Medicare (Medicare patients only–inpatient) _____ Initials ❑ Not Applicable
- Observation Notice _____ Initials ❑ To Be Determined

- I have an Advance Directive (Living Will) ❑ Yes* ❑ No
  *If a copy is not in your record, please bring a copy to your next visit.

- Do you want information about Advance Directives or appointing a Health Care Agent? ❑ Yes ❑ No

**I understand and agree to the contents of this form.**

| | | | |
|---|---|---|---|
| Signature of Patient or Patient Representative | Date/Time | Signature of Witness | Date/Time |
| Printed Name of Patient Representative (if applicable) | | Personal Representative Relationship to Patient (if applicable) | |

**If patient unable to sign AND healthcare agent or surrogate not available, attempt telephone consent.*

## Receipt of Entity General Consent via Telephone

**Name of Patient or Representative Providing Telephone Consent:** _____
Printed Name

**Relationship to Patient:** _____
Printed Relationship

**Associate Obtaining Telephone Consent:** _____
Printed Name

_____
Date

## *MedStar Healthcare Entity Associate Section:

Complete this section if patient representative or telephone consent obtained to indicate reason patient did not sign form.

Check only one:

❑ Emergency Patient ❑ Direct Admit/Transfer ❑ Incapacitated
❑ Clinical team concern for capacity ❑ Physical impairment
❑ No representative information available ❑ Other (please specify) _____

Associate Initials: _____

**This form needs to be signed at each ED and inpatient occurrence and annually for outpatient visits.**