Consent to Routine Procedures and Treatment & Financial Responsibility Statement

SECTION 1

Consent to Routine Procedures and Treatments

I consent to routine procedures and treatments at a Wellstar Health System "Wellstar" facility as an outpatient, inpatient, or emergency department patient, depending on my medical needs. Routine procedures and treatments can include testing (for example, X-rays and blood tests), standard care (for example, intravenous fluids, injections, or bladder stomach tubes), and evaluations (interviews and physical exams). However, this consent to routine procedures and treatments do not include authorization for other invasive procedures (for example, surgery, amniocentesis, or diagnostic tests such as colonoscopy or those requiring the use of contrast material), consent for blood or blood products, general anesthesia or my participation in research. These circumstances require a separate consent process. I understand it is the responsibility of my physician or surgeon to obtain any required individual consent.

I understand that I may receive treatment and healthcare services given by Wellstar team members (such as nurses and technicians) and by physicians and other independent medical professionals on the medical staff of Wellstar facilities (for example, emergency department physicians, radiologists, and surgeons) who are NOT Wellstar team members. I understand that the healthcare services provided by these independent medical professionals, using independent medical judgment at a Wellstar facility in no way create any type of employment, partnership or other relationship other than as an independent contractor. These independent contractors are responsible for their own actions and Wellstar shall not be liable for the acts or omissions of any such independent contractors.

While I am a patient at a Wellstar facility, I understand that I may be observed by or receive healthcare services from students enrolled in training programs. Students are supervised by instructors, Wellstar team members, or other independent medical professionals on the medical staff of the Wellstar facility, depending on the type of training program the students are enrolled in. I understand that I have the right to request that someone other than a student provide my care.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of procedures or treatment given to me. I further understand that Wellstar has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual practices.

I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and their affiliation with Wellstar) at any time. I understand the practice of medicine is not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks or even death. I understand that no guarantees can be made as to the outcome of my care.

SECTION 2

Maternity Patients

If I deliver an infant(s) while I am a patient at a Wellstar facility, I agree that this same consent applies to the infant(s).

SECTION 3

Emergency or Laboring Patients

Under federal law, I understand my right to receive an appropriate medical screening examination performed by a physician or other qualified medical professional to determine whether I am suffering from an emergency medical condition. If such a situation exists, stabilizing treatment will be provided within this Wellstar facility's capabilities and staff even if I cannot pay for these services, do not have medical insurance coverage, or am not entitled to Medicare or Medicaid.

Wellstar

[ ] AMC [ ] AMC South [ ] Cobb [ ] Douglas [ ] Kennestone [ ] North Fulton

[ ] Paulding [ ] Spalding Regional [ ] Sylvan Grove [ ] WGMC [ ] Windy Hill [ ] WMG

General Consent to Treat and Financial Responsibility Statement

SECTION 4

Assignment of Benefits/Financial Responsibility

I assign any right I may have to receive payment from a health insurance plan, ERISA, Medicare, Medicaid, Social Security, or other payors for services rendered by Wellstar and the medical professionals caring for me during my treatment. I understand that I am financially responsible for all healthcare services, including amounts that are not covered by my health insurance plan or payer, as appropriate, based on the terms of the health plan contracts or the law. For example, the payment of non-covered services, deductibles, and co-payments is the patient's responsibility. For healthcare services provided by independent medical professionals, I understand that I will receive separate bills and be responsible for paying them. I agree to deliver Wellstar with all health insurance coverage information if I choose to use my insurance to pay for services. I agree to respond to all requests for benefits information and complete any forms required by my insurance plan. I am responsible for understanding and following the terms of my health insurance plan. I authorize Wellstar and its medical professionals to submit appeals for payment, including arbitration and formal complaints, on my behalf as required by my insurance company. I also understand that I am financially responsible for collection costs if my account becomes delinquent. All delinquent accounts will bear interest at the standard rate unless prohibited by law. I understand that Wellstar may request and use data from third parties such as credit reporting agencies to verify demographic data or evaluate financial options.

For Medicare/Medicaid Patients: I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges to Wellstar or the independent medical professionals providing healthcare services to me. I understand that I am responsible for any remaining balance not covered by other insurance. If I am signing this form and am not the patient, I understand that I am also responsible for and agree to pay charges not covered by the assignments made in this Section IV, including any Medicare deductibles.

SECTION 5

Financial Assistance Statement

It is Wellstar's policy to provide medical care at no cost to qualified members of the Wellstar-served communities, and to provide significantly discounted medical care to certain qualified members of our communities faced with financial hardship due to medical misfortune, according to policy. I understand that if payment of my bill creates a financial hardship, I may qualify for assistance with all or part of my medical expenses associated with my treatment at a Wellstar facility and that I can call (678) 838-5750 for more information.

SECTION 6

Consent to Photography and Videotapping

Sometimes, Wellstar facilities and physicians use patient photographs and videos for identification, clinical education, or research-related purposes. These photographs, recordings, or videos could be in digital or other formats and may be reproduced for scientific or treatment reasons. I consent to having photographs, recordings or videos taken for patient care, educational, research, or other clinical benefits.

SECTION 7

Notice Regarding Release of Health Information

As explained in Wellstar's Notice of Privacy Practices, Wellstar may use and disclose medical information including privileged information (for example, mental health, alcohol/drug abuse or HIV/AIDS), to physicians or other healthcare providers for the purposes of providing treatment, and payers for the purposes of payment for medical treatment. HIPAA also permits Wellstar and its affiliated companies to use medical information for healthcare operations. I expressly authorize Wellstars use and disclosure of my medical information as described in this Section.

SECTION 8

Inpatient Information

I have received a copy of the Patient Admission Packet that includes "Patient Rights and Responsibilities and information regarding Advance Care Planning. If I am a Medicare benefciiary, I have also received a notice entitled "Important Message from Medicare."

SECTION 9

Advance Directive

I have an Advanced Directive: [ ] Yes [ ] No

If yes, I will provide a copy to Wellstar. I have been advised that Wellstar does not honor Advanced Directives in Pre-admission Testing or in the Outpatient Diagnostics and Treatment setting.

SECTION 10

Personal Valuables

I understand that Wellstar is not liable for lost or damaged personal belongings and valuables (for example, money, jewelry, hearing aids, or dentures) unless placed in a Wellstar safe. I will ask family members or friends to take home my personal belongings and valuables. I also understand and inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics, or other items that I need to retain close by for personal functioning to assure safekeeping.

SECTION 11

Consent to Contact

By providing a telephone number, I expressly consent and authorize Wellstar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source included but limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to healthcare law, healthcare coverage, care followup, and other healthcare opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to conact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Patient/Representative Signature	Date	Time
Relationship to patient (if applicable)		
Witness Signature	Date	Time
Printed name of witness		
Name of interpreter (if applicable)		