Delivery Network/Location

NAME:

BIRTH DATE:

MRN:

DOS:

(If handwritten, patient name, MRN, birth date, and DOS)

Yale New Haven Health & Yale Medicine

Patient Acknowledgement and Financial Authorization

A. CONSENT FOR TREATMENT: I[1] consent to being admitted/treated as a patient of Yale New Haven Health ("YNHH") and Yale Medicine ("YM") for the purpose of receiving medical care and treatment and/or diagnostic procedures. I understand and agree that: (i) YNHH and YM are teaching institutions and students may be involved in observing and giving care unless I disagree; (ii) all attending physicians have privileges to practice at YNHH facilities, but not all physicians are agents or employees of YNHH or YM; (iii) I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that discussion of the risks, benefits and alternatives to each procedure or treatment is available to me; (iv) as part of my medical care and treatment I may be tested for HIV, and that this testing is voluntary. I will notify my care provider if I do not agree to HIV testing; and (v) photographs, videotaped images or other images may be made of me for purposes of medical documentation or education as YNHH, YM or its medical staff deem appropriate. I understand that these images will be stored in a secure manner that will protect my privacy. Images that identify me will be released and/or used outside the institution only with my written authorization or that of my legal representative; (vi) the institution may use audio/video monitoring to enhance my care in some locations or video monitoring for patient safety; (vii) leftover blood, fluids or tissue may be used for scientific research or teaching by appropriate persons and that I will no longer have any rights to them.

B. AUTHORIZATION FOR PAYMENT/FINANCIAL AGREEMENT: I agree to pay YNHH and YM for all services and supplies provided to me, and for any other applicable charges. I authorize and direct my insurance carrier, health sharing ministry, discount plan or another entity ("Payor") to make payment to YNHH and YM of all insurance or other benefits, including authorized Medicare benefits, and assign my rights to YNHH and YM. I have requested that YNHH and YM first seek payment for the medical services provided from such Payor. I understand that by agreeing to do so, YNHH and YM have not agreed to accept less than full payment of amounts due and owing from any such entity unless YNHH and YM have an existing contract with such entity to accept reduced payment for the services provided. Regardless of what my identification card says, I understand and agree that I may be billed, and will be obligated to pay, for any such amount not paid by my Payor, to the extent permitted by law. I agree to pay any remaining balance not covered by my insurance plan or not paid by any Payor. If I receive payment from my insurance company or other Payor for services provided to me by YNHH and YM, I agree to submit the payment to the hospital and/or YM. If my account is not paid, I will pay all costs incurred as a result of YNHH's and/or YM's collection efforts, including, without limitation, attorneys' fees and court costs. As a courtesy, YNHH or YM may assist me in processing insurance claims, however, YNHH and YM accept no responsibility for any processing procedures, acts, omissions or neglect. Any amounts not paid by my insurer become due and payable when the bill is mailed or on demand. If my bill is not paid in full, YNHH and YM reserve the right not to provide any future non-emergency medical services to me. YNHH has a Charity Care program for eligible persons who do not have insurance or cannot pay bills. To be considered for Charity Care, I may need to apply to Medicaid and meet other requirements.

C. SEPARATE HOSPITAL & PHYSICIAN SERVICES: I understand that when I am treated in a Hospital or in a Hospital Outpatient Department that I will receive separate bills for hospital services and physician services, which I would not receive if the services were provided in an office that is not hospital-based. I understand that I will be subject to separate coinsurance liabilities for each separate bill, and that additional information, including an estimate of my out-of-pocket liability, is available to me at each Hospital facility. I understand that this consent and authorization applies to physician services, as applicable, to the same extent as it applies to YNHH and YM.

D. RELEASE OF INFORMATION: I understand that YNHH and YM can release all necessary health information for purposes of treatment, payment and healthcare operations. I authorize the release of any HIV/AIDS-related information, drug and alcohol abuse treatment information, and information about diagnosis or treatment of mental illness, to other treating providers and to third-party payers, including but not limited to insurance companies, managed care organizations, Medicare, Medicaid, and other governmental payors. I understand that YNHH and YM may release any and all necessary information with respect to my treatment when required to do so by law, including the mandatory reporting of certain communicable diseases (including but not limited to tuberculosis and HIV) to the State Department of Public Health.

I understand that refusal to consent to release of health information will not jeopardize my right to obtain present or future treatment, except where disclosure is necessary for the treatment. I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. The authorization provided in this Section D expires one year from the date of discharge from the Hospital if inpatient, or one year from the last date of treatment in an outpatient department or physician office. I understand that if I refuse to authorize release of information and this results in a refusal by my insurance company or other responsible payor to pay YNHH or YM for my treatment, I will be responsible for the entire unpaid portion of my bill.

E. COMMUNICATIONS VIA PHONE: If I have provided a telephone number as a primary telephone contact, I hereby authorize YNHH and YM, along with their respective employees, agents, and business associates, to contact me via phone or text message for any reason, including, without limitation, automated notifications and appointment reminders.

F. PERSONAL VALUABLES: I hereby understand and acknowledge the following: (i) I accept sole responsibility for all personal property retained by me in a YNHH or YM facility; (ii) I have been advised not to keep any valuables with me while I am a patient of a YNHH or YM facility; (iii) neither YNHH nor YM is responsible for any lost items; (iv) for inpatient or outpatient stays, the use of a security vault may be available upon my request, and I must sign an additional form for its use; and (v) YNHH and YM reserve the right to inspect and to prohibit inappropriate or unsafe items, such as drugs, alcohol, weapons, cellular phones, etc.

G. TELEHEALTH: I understand that Yale New Haven Health and Yale Medicine may use telehealth tools to enhance my care, and/or ensure my safety, and that of my care team. These tools may include, but are not limited to asynchronous communications or evaluations between consulting providers as well as interactive audio/video technologies and monitoring that allow my caregivers to assess my current presentation and provide care virtually.

_____ the _____ hereby give consent on his/her behalf
Printed Name of patient / patient representative

Time _____ Date _____ Signature of patient / patient representative _____ Printed Name of patient / patient representative _____

Interpretation Services (if necessary): An interpreter facilitated the communication between the health care provider(s) and the patient or person authorized to consent for the patient in _____ (language) to assist in obtaining informed consent.
The interpreter conveyed the content of the original information expressed by and for both parties.
Time: _____ AM/PM Date: _____
Check here if: ☐ Telephone ☐ Video Interpreter ☐ Interpreter ☐ Bilingual Competency Program
ID Number (telephone/video only): _____

_____ _____
Print Name of Interpreter **Interpreter (face to face only)**

[1] "I" shall mean the patient or the individual authorized to sign on behalf of the patient