

Provider ID Group #: _____ Primary Coverage Member ID: _____
Secondary Coverage Member ID: _____

CONSENT FOR TREATMENT:

- I consent to receiving care at Tower Health Medical Group which is necessary or beneficial, including, but not limited to, the administration of medications, injections, x–ray examinations, laboratory procedures, and hospital services as may be deemed necessary or advisable by my care provider(s).
- I understand that care provider(s) may not be employed by or agents of Tower Health Medical Group, but has/have the right to practice medicine at Reading Hospital. I may be billed separately for services provided by these providers.
- I understand that my healthcare team may be comprised of physicians, physician assistants, nurse practitioners, nurses, technicians, residents, students, other employees, and agents.
- I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees are made as to the results of my treatment or procedures performed.
- I understand that for my health and protection, as well as the protection of others, I will not be permitted to have weapons, illicit drugs, alcoholic beverages or unauthorized electrical appliances with me during my care/treatment.
- I understand that during my treatment photographing, videotaping, audio recording, and/or televising (Recordings) may occur for care/treatment or identification purposes and will become part of my medical record.
- I understand that Recordings may be taken for education, training, educational/research publication, or quality assurance purposes. These recordings will not reveal my identity and will not become part of my medical record.
- I understand that I have the right to refuse any medications, treatment, procedures, or Recordings to the extent permitted by law.

TELEMEDICINE SERVICES:

- I understand that my treatment may include participation in a Telemedicine service/consultation. If this occurs:
 - My health care provider and I may communicate by interactive video conferencing with Pennsylvania licensed physicians and health care professionals at another location.
 - Digital images of my medical condition may be made and sent to Pennsylvania licensed physicians and other health care professionals at other locations for evaluation and consultation with my health care professional.
 - Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
 - The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained in the use of telemedicine which identifies me will be disclosed except as authorized by law.
 - I have the right to withhold or withdraw my consent to the use of telemedicine in my care at any time. This will not affect my right to future care. I understand that if telemedicine is not used, I may not have access to specialists who are not available in the community.

AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:

- I understand that the facility and Tower Health Medical Group have a system–wide, integrated electronic medical record that is available to caregivers on a "need to know" basis to share information about patient care provided in the hospital, outpatient, or physician office settings.
- I understand confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS, or drug or alcohol treatment is maintained per relevant governmental and regulatory standards.
- I understand that my After Visit Summaries are automatically sent to designated Tower Health Medical Group and/or other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care.

HEALTH INFORMATION EXCHANGES (HIEs) PARTICIPATION:

- I agree to participate in "Health Information Exchanges (HIEs)," which allow my healthcare providers to access my protected health information from other participating providers from whom I have received care.
- I understand that I have the option to "opt out" from sharing my protected health information with the HIEs.
- I understand if I choose to "opt out" that my choice will not affect my ability to receive medical care.

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AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION:

- I understand that I may choose to be listed in Facility's public information directory. This means that my room number, telephone number and general condition can be released as a matter of public record.
- I understand that if I elect not to be listed in the Facility's public information directory, my presence in the Facility will not be acknowledged to the general public, and that I will not receive mail, telephone calls, visitors, or gifts.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:

- I understand that the facility and Tower Health Medical Group do not accept responsibility for loss or damage to any monies, valuables, and/or personal property brought to Reading Hospital or Tower Health Medical Group.
- As an inpatient of the facility, I have been advised to send all monies, valuables, and/or personal property home with a family member, or if that is not possible, to deposit them in the facility safe.
- While a patient of the facility, I release the facility from any responsibility due to loss or damage to monies, valuables, and/or personal property that are not deposited in the facility safe.

PATIENT RIGHTS AND RESPONSIBILITIES:

- I understand that I have patient rights which reflect the Reading Hospital's and Tower Health Medical Group's commitment to maintaining my personal dignity while providing me with the healthcare services I need.
- I understand that I have responsibilities to provide the healthcare team with certain information and support.
- I understand that I have the responsibilities to respect the rights of others.
- I understand that if I have any concerns regarding my care, I may talk with my doctor, nurse or any member of my healthcare team. I may also contact the Patient Advocate Office.

MEDICAL ASSISTANCE VERIFICATION:

- If I am a recipient of Medical Assistance, I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material information may be prosecuted under applicable Federal and State laws.

ACKNOWLEDGEMENT FORM:

- I have read this form (or have had it read to me) in its entirety, have had any questions answered to my satisfaction, consent to each of the above provisions, and am signing this form knowingly and voluntarily.

Signature of Patient or Authorized Individual

Date

Time

Printed Name of Patient or Authorized Individual

Relationship to Patient

Signature of Authorized Agent/Rep.

Date

Time

Printed Name of Authorized Agent/Rep.

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