Penn Medicine
Princeton Health

GENERAL CONSENT FORM

Place Patient Label Here

Thank you for choosing Penn Medicine Princeton Health. Penn Medicine Princeton Health is part of the University of Pennsylvania and its Health System. The care you receive at Penn Medicine Princeton Health may include care by Penn Medicine Princeton Medical Center, Penn Medicine Princeton Medicine Physicians, and/or other affiliated practices or facilities, and each of its authorized agents, medical staff, employees, and designees (all together, "Penn Medicine Princeton Health").

I have read and understood each paragraph below, and by signing give consent voluntarily.
If signing electronically, I accept and intend the signature(s) below to be legally binding and the equivalent of my handwritten signature.

Patient Signing:

Patient Printed Name	Patient Signature	Date	Time

Legally Authorized Representative Signing:

Print Name	Signature	Date	Time

Relationship to Patient

Penn Medicine Princeton Health Representative Signing:

Print Name	Signature	Date	Time	Entity

CONSENT TO CARE: I present myself for outpatient care and/or admission to Penn Medicine Princeton Health. I voluntarily consent to care including routine tests and treatment. I know that no guarantees have been made to me about the results of the care provided. I also voluntarily consent to HIV and Hepatitis testing, and testing for other blood and fluid-borne pathogens, if a healthcare worker is exposed to my blood or other bodily fluids. I understand that Penn Medicine Princeton Health has a relationship with Rutgers Robert Wood Johnson Medical School and other teaching institutions. I agree that those in training programs may take part in my care. I understand that for the purpose of my care, certain of my tissue(s), bodily substances, and/or fluids may be removed and used, modified, disposed of, or transferred by Penn Medicine Princeton Health. I agree that any remaining tissue(s), bodily substances, and/or fluids may be used for education and research not specifically related to my care. If such material identifies me, research use will occur only with my permission. I understand that video, audio, and/or digital recordings/images of my treatment by Penn Medicine Princeton Health may be taken, and may be used for:

- Quality improvement and education, in which case the recordings/images will not become part of my medical record and will be erased after review. I have the right to decline the recording or image collection or its use for purposes of quality improvement and education; and
- Consultative services and treatment by healthcare providers at a distant site, such as another hospital, authorized by Penn Medicine Princeton Health, which may include interactive video, audio, and telecommunications technology (also known as "telemedicine"). Details of my health history, examinations, x-rays, tests, and medical record may be reviewed by and discussed with these other healthcare providers at these distant sites and other hospitals.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION: I understand and consent that Penn Medicine Princeton Health is permitted to use and disclose health information about me in any form including electronic for **treatment, payment, and healthcare operations** and as otherwise allowed by law. This includes sharing my health information with:

- Penn Medicine Princeton Health or outside providers involved in my care, and family members or friends involved in my care.
- People or parties responsible for payment for the care I receive, such as insurance companies, managed care companies, government programs and agencies such as Medicare, and each of their agents or auditors.

SPECIFIC CONSENT TO USE AND DISCLOSE SPECIAL RECORDS: I understand that Federal and state law specially protect certain types of health information and records, including those relating to treatment for mental health, HIV or AIDS, and/or substance use ("Special Records"). Such laws allow Penn Medicine Princeton Health to use and share Special Records for my care and treatment and for other specific purposes. In other circumstances, Penn Medicine Princeton Health will obtain special patient consent to release records. Questions on privacy issues may be directed to PMPH-PrivacyOfficer@PennMedicine.Upenn.edu.

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND COLLECTIONS, AUTHORIZATION TO PAY PHYSICIAN: In consideration of services to be rendered by Penn Medicine Princeton Health, I hereby authorize my health care insurer(s) (Medicare, Medicaid, Commercial Insurance, Worker's Compensation, Auto Insurance, etc.) to pay Penn Medicine Princeton Health directly for covered services. I accept sole financial responsibility for all services provided and agree to pay amounts not covered by my insurers. I hereby agree to all pre-certification requirements as stated in my health insurance policy. I also agree, in order for Penn Medicine Princeton Health to service my account or to collect any amounts I may owe, that Penn Medicine Princeton Health may contact me or my authorized representative by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. In addition to my hospital bill, I may also receive separate bills from other healthcare professionals such as radiologists, cardiologists, pathologists, or neonatologists who deliver services to me at Penn Medicine Princeton Health during my visit. I hereby authorize payment to be made directly to any and all of my treating physicians by my insurer(s). I understand physicians assigned to my care contract with insurers independently of Penn Medicine Princeton Health and may not participate in my insurance plan. I accept sole financial responsibility for all physician services provided and agree to pay amounts not covered by my insurers.

Patient/Authorized Representative Phone Number: _____ Initials: _____

PHYSICIAN DISCLAIMER: Most physicians on staff at Penn Medicine Princeton Health, including, but not limited to emergency physicians, pathologists, radiologists, anesthesiologists, and other hospital-based physicians, are not employees or agents of Penn Medicine Princeton Health. All such physicians are independent physicians who have been granted the privilege of using this facility for the care and treatment of their patients.

INPATIENT AND BEDDED OUTPATIENT ONLY ACKNOWLEDGEMENTS

RELEASE OF RESPONSIBILITY FOR VALUABLES/BELONGINGS RETAINED BY PATIENT: I understand that Penn Medicine Princeton Health is not responsible for the loss of or damage to any valuables such as money or personal items (including, but not limited to, dentures, hearing aids, eyeglasses, jewelry, and prostheses) which I retain during my stay at Penn Medicine Princeton Health. I understand that it is recommended that any valuables I have be sent home with family or friends, and I understand that I accept full responsibility for any items I retain in my possession during my stay at Penn Medicine Princeton Health. Room safes will be made available for all Penn Medicine Princeton Health inpatient admissions and patients may utilize them at will. I understand that I am responsible for all content placed in the safe.

RELEASE OF PATIENT INFORMATION TO OUTSIDE RELIGIOUS MINISTRIES: I understand that chaplains from Penn Medicine Princeton Health's Department of Religious Ministries may visit me periodically during my stay to offer emotional and spiritual support. I also understand that if I list my specific place of worship below, Penn Medicine Princeton Health will include my name and location in the facility on a list for congregational clergy from my specific place of worship to view if they are making rounds at Penn Medicine Princeton Health. If I am Catholic and would like to receive daily communion, I will list myself as Catholic below. **By initialing below, I am agreeing to be listed in the Religious Ministries Directory.** Initials: _____

If initialed, please complete the following:

Religious Preference: _____ Place of Worship: _____

NOTIFICATION OF ADMISSION TO PRIMARY CARE PHYSICIAN: I hereby allow Penn Medicine Princeton Health to notify my primary care physician that I have been admitted to the hospital.

Primary Care Physician Name: _____ Phone Number: _____

GENERAL ACKNOWLEDGMENTS FOR INPATIENTS/BEDDED OUTPATIENTS ONLY:

❑ I hereby acknowledge that I have been advised that optional telephone service is available in every room but requires an additional fee.
❑ I hereby acknowledge that I have received or have been offered a copy of "Advance Directive Information" to read, and any questions I had were answered to my satisfaction.
❑ I hereby acknowledge that, if applicable, I have received or have been offered a copy of the advice entitled "Important Message from Medicare."

GENERAL ACKNOWLEDGMENTS:

❑ I hereby acknowledge that I have received or have been offered a copy of Penn Medicine Princeton Health's "Patient Rights" to read, and any questions I had were answered to my satisfaction.
❑ I hereby acknowledge that I have received or have been offered a copy of Penn Medicine Princeton Health's "Joint Notice of Privacy Practices" to read, which describes how medical information about me may be used and disclosed and how I can get access to this information, and any questions I had were answered to my satisfaction.
❑ I hereby acknowledge that I have received or have been offered a copy of Penn Medicine Princeton Health's "Section 1557 Nondiscrimination in Health Programs and Activities Notice" to read, which describes Penn Medicine Princeton Health's compliance with federal civil rights laws, and any questions I had were answered to my satisfaction.