

## CLINIC/HOSPITAL AUTHORIZATIONS

MRN:2592229

AGE:20 y.o.

DOB:05/22/1997

SEX:male

## AUTHORIZATIONS

**A. Consent for Examination and Treatment:** I hereby authorize the providers and employees of Ochsner Health System ("Ochsner") to provide medical treatment/services which includes, but is not limited to, performing and administering tests and diagnostic procedures that are deemed necessary, including, but not limited to, imaging examinations, blood tests and other laboratory procedures as may be required by the hospital, clinic, or may be ordered by my physician(s) or persons working under the general and/or special instructions of my physician(s).

1. I understand and agree, that this consent covers all authorized persons, including but not limited to physicians, residents, nurse practitioners, physicians' assistants, specialists, consultants, student nurses, and independently contracted physicians, who are called upon by the physician in charge, to carry out the diagnostic procedures and medical or surgical treatment.
2. I hereby authorize Ochsner to retain or dispose of any specimens or tissue, should there be such remaining from any test or procedure.
3. I hereby authorize and give consent for Ochsner providers and employees to take photographs, images or videotapes of such diagnostic, surgical or treatment procedures of Patient as may be required by Ochsner or as may be ordered by a physician. With the exception of radiologic images, Ochsner is not obligated and does not retain videotapes or photographs for any period of time, if the medical record contains a record of the surgical, diagnostic or treatment procedure. I further acknowledge and agree that Ochsner may use cameras or other devices for patient monitoring.
4. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the outcome of any tests, procedures or treatment.

**B. Authorization for Release of Information:** I understand that my insurance company and/or their agents, may need information necessary to make determinations about payment/reimbursement. I hereby provide authorization to release to all insurance companies, their successors, assignees, other parties with whom they may have contracted, or others acting on their behalf, that are involved with payment for any hospital and/or clinic charges incurred by the patient, any information that they request and deem necessary for payment/reimbursement, and/or quality review.

**C. Medicare Patient's Certification and Authorization to Release Information and Payment Request:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**D. Assignment of Insurance Benefits:** I hereby authorize any and all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses to pay all hospital and medical benefits now due, and to become due and payable to me under any hospital benefits, sick benefits, injury benefits or any other benefit for services rendered to me, including Major Medical Benefits, direct to Ochsner and all independently contracted physicians. I assign any and all rights that I may have against any and all insurance companies, health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses, including, but not limited to any right to appeal a denial of a claim, any right to bring any action, lawsuit, administrative proceeding, or other cause of action on my behalf. I specifically assign my right to pursue litigation against any and all insurance companies,

health plans, defined benefit plans, health insurers or any entity that is or may be responsible for payment of my medical expenses based upon a refusal to pay charges..

**E. Valuables:**It is understood and agreed that Ochsner is not liable for the damage to or loss of any money, jewelry, documents, dentures, eye glasses, hearing aids, prosthetics, or other property of value.

**F. Computer Equipment:**I understand and agree that should I choose to use computer equipment owned by Ochsner or if I choose to access the Internet via Ochsner's network, I do so at my own risk. Ochsner is not responsible for any damage to my computer equipment or to any damages of any type that might arise from my loss of equipment or data.

**G. Acceptance of Financial Responsibility:** I agree that in consideration of the services and supplies that have been or will be furnished to the patient, I am hereby obligated to pay all charges made for or on the account of the patient according to the standard rates (in effect at the time the services and supplies are delivered) established by Ochsner, [including its Patient Financial Assistance Policy to the extent it is applicable]. I understand that I am responsible for all charges, or portions thereof, not covered by insurance or other sources. Patient refunds will be distributed only after balances at all Ochsner facilities are paid.

**H. Relationship Between Facility and Physician:** I understand that some, but not all, providers furnishing services to the patient are not employees or agents of Ochsner. The patient is under the care and supervision of his/her attending physician, and it is the responsibility of the facility and its nursing staff to carry out the instructions of such physicians. It is the responsibility of the patient's physician/designee to obtain the patient's informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the special instructions of the physician/designee.

**I. Acknowledgment of Receipt of Smoking Cessation Materials:** I certify that I have received the information sheet "Smoking: How to Quit."

**J. Notice of Privacy Practices:**I acknowledge I have received a copy of Ochsner's Notice of Privacy Practices.

**K. Facility Directory:** I have discussed with the organization my desire to be either included or excluded in the facility directory. I understand that if my choice is to opt-out of being identified in the facility directory that the facility will not provide any information about me such as my condition (e.g. fair, stable, etc.) or my location in the facility (eg room number, department).

**L. LINKS:**Ochsner is a LINKS (Louisiana Immunization Network for Kids Statewide) participating facility. LINKS is a DHH-sponsored confidential computer system that helps you and your doctor keep track of you and your child's immunization history. I acknowledge that I am allowing Ochsner to share this information with LINKS.

**M. TERM:** This authorization is valid for this and subsequent care/treatment I receive at Ochsner and will remain valid unless/until revoked in writing by me.

**N. OCHSNER HEALTH SYSTEM:** As used in this document, Ochsner Health System means all Ochsner affiliated entities including all health centers, surgery centers, and hospitals. It includes, more specifically, the following entities: Ochsner Clinic Foundation, Ochsner Community Hospitals, a not for profit Louisiana corporation, individually and as manager and on behalf of Ochsner Baptist Medical Center, L.L.C., Ochsner Medical Center- Kenner. L.L.C., Ochsner Medical Center-Westbank, L.L.C., Ochsner Bayou, LLC d/b/a/ Ochsner St. Anne General Hospital, East Baton Rouge Medical Center, LLC d/b/a Ochsner Medical Center Baton Rouge, and Ochsner Medical Center - Northshore, LLC.

1/31/2018



