Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville, TN 37804-5016 865-983-7211

Blount Memorial Hospital Consent/Release Form

Place Patient Label Here or Print Patient's Name and Date of Birth

CONSENT FOR TREATMENT, PROCEDURES, TESTS AND CARE: I KNOWINGLY CONSENT TO ANY TREATMENT, PROCEDURES, TESTS AND CARE ("CARE") FOR WHICH BLOUNT MEMORIAL HOSPITAL AND/OR ITS ENTITIES ("FACILITY") IS REQUESTED TO PROVIDE ME, INCLUDING CARE AT FACILITY BOTH AS AN INPATIENT OR OUTPATIENT. I UNDERSTAND MY RIGHT TO QUESTION OR REFUSE CARE. BY REFUSING CARE, I UNDERSTAND I HAVE RELEASED AND WAIVED ANY LIABILITY OF FACILITY, ITS EMPLOYEES, ITS AGENTS, AND MY PHYSICIAN. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT, CARE OR EXAMINATIONS IN THE HOSPITAL. I AUTHORIZE BLOUNT MEMORIAL HOSPITAL, MARYVILLE, TN TO RETAIN, PRESERVE AND USE FOR SCIENTIFIC OR TEACHING PURPOSES, OR DISPOSE OF AT ITS CONVENIENCE ANY SPECIMENS OR TISSUES TAKEN FROM MY BODY.

ASSIGNMENT OF BENEFITS: I AUTHORIZE DIRECT PAYMENT TO FACILITY OF ALL HOSPITALIZATION/FACILITY BENEFITS OTHERWISE PAYABLE TO ME BY ANY PAYOR INCLUDING MEDICARE, TENNCARE, CHAMPUS/CHAMPVA, ANY OTHER THIRD PARTY PAYOR AND MY PERSONAL INSURANCE, INCLUDING MEDICAL PAYMENT BENEFITS, PERSONAL INJURY PROTECTION, UNINSURED AND UNDERINSURED BENEFITS. I UNDERSTAND THAT MY INSURANCE COMPANY MAY NOT COVER ALL SERVICES AND CARE, AND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND/OR EXPENSES INCLUDING ANY DRUGS MEDICARE CONSIDERS SELF-ADMINISTERED. I FURTHER UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLES AND/OR CO-INSURANCE PAYMENTS ASSOCIATED WITH MY CARE, AND THAT IT IS MY RESPONSIBILITY TO ASSURE PROPER NOTIFICATION/AUTHORIZATION IS OBTAINED FROM MY INSURANCE COMPANY IF REQUIRED FOR PAYMENT. I UNDERSTAND THAT ANY FAILURE TO COMPLY WITH PROPER NOTIFICATION/AUTHORIZATION REQUIREMENT CAN RESULT IN MY BEING PERSONALLY RESPONSIBLE FOR ALL CARE CHARGES AT FACILITY.

PAYMENT OF BILLS: THE UNDERSIGNED AGREES, WHEN HE/SHE SIGNS AS PATIENT, PATIENT'S AGENT, ATTORNEY, GUARDIAN, CONSERVATOR, OR OTHER RESPONSIBLE PARTY, THE PATIENT IS LIABLE FOR THE PAYMENT OF THE FACILITY ACCOUNT IN ACCORDANCE WITH FACILITY'S RATES AND TERMS. I FURTHER UNDERSTAND ANY DELINQUENT ACCOUNT WILL BE SENT FOR COLLECTION EFFORTS AFTER NOTICE, AND THAT I AGREE ANY COLLECTION COSTS OR FEES, INCLUDING ATTORNEY FEES, ASSOCIATED WITH THE COLLECTION OF MY ACCOUNT ARE MY RESPONSIBILITY, AND MAY BE ADDED TO ANY UNPAID AMOUNT OWED FACILITY FOR MY CARE. I UNDERSTAND THAT FINANCIAL ASSISTANCE IS AVAILABLE TO THOSE WHO QUALIFY AND I CAN GET ADDITIONAL INFORMATION BY CONTACTING THE BUSINESS OFFICE. I AGREE, IN ORDER TO SERVICE MY ACCOUNT, OR TO COLLECT ANY AMOUNTS I MAY OWE, THE FACILITY MAY CONTACT ME BY TELEPHONE AT ANY TELEPHONE NUMBER ASSOCIATED WITH MY ACCOUNT, INCLUDING WIRELESS TELEPHONE NUMBERS, WHICH COULD RESULT IN CHARGES TO ME. THE FACILITY MAY ALSO CONTACT ME BY SENDING TEXT MESSAGES OR E-MAILS, USING ANY E-MAIL ADDRESS I PROVIDE TO THEM. METHODS OF CONTACT MAY INCLUDE USING PRE-RECORDED/ARTIFICIAL VOICE MESSAGES AND/OR USE OF AN AUTOMATIC DIALING DEVICE, AS APPLICABLE. I ALSO UNDERSTAND THAT MY CONTACT INFORMATION MAY BE SHARED WITH ANCILLARY PROVIDERS FOR TREATMENT AND PAYMENT PURPOSES.

HEALTH INFORMATION EXCHANGE: I UNDERSTAND AND AGREE THAT MY PROTECTED HEALTH INFORMATION MAY BE ACCESSED, USED AND DISCLOSED THROUGH A REGIONAL HEALTH INFORMATION ORGANIZATION (RHIO). THE RHIO CURRENTLY AVAILABLE IN OUR AREA IS NAMED eTHIN (EAST TENNESSEE HEALTH INFORMATION NETWORK). FURTHER, I UNDERSTAND THAT THE FUNCTION OF eTHIN IS TO SHARE HEALTH INFORMATION ACROSS THE AREA, TO FACILITATE BETTER CARE BETWEEN HEALTH CARE PROVIDERS IN THE REGION AND FACILITATE BETTER MEDICAL CARE FOR PATIENTS LIVING IN EAST TENNESSEE. AS SUCH, I UNDERSTAND THAT ONLY THOSE HEALTH CARE PROVIDERS WHO ARE TREATING ME AND PARTICIPATING IN eTHIN MAY ELECTRONICALLY ACCESS MY HEALTH INFORMATION FROM ANY PROVIDER (ie PHYSICIAN, HOSPITAL, CLINIC OR OTHER HEALTH CARE PROVIDER) PARTICIPATING IN eTHIN. AS OUTLINED IN THE HEALTH INFORMATION EXCHANGE PATIENT RELEASE FORM, I UNDERSTAND I HAVE OPTIONS REGARDING MY PARTICIPATION.

NOTIFICATION OF FAMILY, DURABLE POWER OF ATTORNEY FOR HEALTHCARE, EMERGENCY CONTACT OR SURROGATE: IN THE EVENT THERE IS A SIGNIFICANT CHANGE IN MY CONDITION OR I EXPERIENCE A FALL OR INJURY UNLESS I SPECIFICALLY TELL MY HEALTHCARE PROVIDERS NOT TO DO SO, I UNDERSTAND THAT A MEMBER OF MY FAMILY, DURABLE POWER OF ATTORNEY FOR HEALTHCARE, EMERGENCY CONTACT OR SURROGATE CAN BE NOTIFIED. THIS IS FOR MY SAFETY AND CONTINUUM OF CARE.

TOBACCO FREE CAMPUS: I UNDERSTAND THAT BLOUNT MEMORIAL HOSPITAL FACILITIES ARE TOBACCO FREE, BOTH INSIDE AND OUTSIDE THE BUILDINGS. I AGREE TO REFRAIN FROM SMOKING OR USING TOBACCO PRODUCTS IN OR ON ANY BLOUNT MEMORIAL PROPERTY. IF DEEMED NECESSARY AND REQUESTED I AGREE TO GIVE ALL TOBACCO PRODUCTS AND SMOKING MATERIALS, INCLUDING MATCHES AND LIGHTERS, TO MY FAMILY TO REMOVE FROM THE PROPERTY OR TO THE NURSING STAFF TO DISPOSE OF FOR SAFETY REASONS. I UNDERSTAND I WILL NOT BE PERMITTED TO LEAVE THE PROPERTY TO USE TOBACCO IF AN INPATIENT. I FURTHER UNDERSTAND AND AGREE THAT IF I DO NOT ABIDE BY THE TOBACCO-FREE RULE, I MAY BE ASKED TO TRANSFER TO ANOTHER MEDICAL FACILITY AND I AGREE TO SUCH TRANSFER AND WILL BE RESPONSIBLE FOR MAKING SUCH TRANSFER ARRANGEMENTS.

CONSENT FOR BLOOD TESTING: TO PROTECT AGAINST POSSIBLE TRANSMISSION OF BLOODBORNE-DISEASES, INCLUDING BUT NOT LIMITED TO HEPATITIS-B, HEPATITIS-C, OR ACQUIRED IMMUNE DEFICIENCY SYNDROMS (AIDS), I UNDERSTAND THAT IT MAY BE NECESSARY TO TEST MY BLOOD WHILE I AM PATIENT AT THIS FACILITY. IF, FOR EXAMPLE, A FACILITY EMPLOYEE IS STUCK BY A NEEDLE WHILE DRAWING BLOOD OR SUSTAINS A SCAPEL INJURY, I UNDERSTAND, AND CONSENT, THAT MY BLOOD, AS WELL AS THE EMPLOYEE'S BLOOD, WILL BE TESTED. I FURTHER UNDERSTAND THAT THE TESTING WILL BE AT NO CHARGE TO ME, THE RESULTS WILL BE KEPT CONFIDENTIAL AND MY PHYSICIAN WILL INFORM ME OF THE RESULT.

PERSONAL ITEMS/PROSTHESES AND VALUABLES: I UNDERSTAND THAT THE FACILITY WILL NOT BE RESPONSIBLE FOR THE LOSS OF OR DAMAGE OF PROSTHESES OR PERSONAL ITEMS SUCH AS GLASSES, HEARING AIDS, CONTACT LENSES, DENTURES, PERSONAL CLOTHING OR PERSONAL MEDICATIONS KEPT IN MY POSSESSION. I ALSO UNDERSTAND THAT ANY VALUABLES SHOULD BE SENT HOME WITH A FAMILY MEMBER OR IF VISITING MAIN FACILITY, LOCKED IN THE HOSPITAL SAFE.

PATIENT RIGHTS AND RESPONSIBILITIES: I HAVE BEEN INFORMED THAT I HAVE CERTAIN RIGHTS AND RESPONSIBILITIES AS A PATIENT A POSTED COPY IS AVAILABLE TO ME AT THIS TIME. I HAVE BEEN OFFERED AND RECEIVED A COPY AS I DESIRED AND AM AWARE THAT I WILL HAVE A COPY IN MY PATIENT INFORMATION PACKET IF I AM ADMITTED.

* _____ **RELEASE OF INFORMATION:** I AUTHORIZE THE FACILITY TO RELEASE INFORMATION TO MY PHYSICIAN(S) AND TO ANY THIRD-PARTY PAYOR ("PAYOR") INCLUDING BUT NOT LIMITED TO MEDICARE, TENNCARE, MY PERSONAL INSURANCE COMPANY, CHAMPUS/CHAMPVA, WHEN NECESSARY TO PROCESS MY CLAIM AND DISTINGUISH NEED FOR FURTHER CARE. I UNDERSTAND THAT I MAY OBTAIN A COPY OF MY MEDICAL RECORDS FROM FACILITY'S HEALTH INFORMATION MANAGEMENT DEPARTMENT AFTER SIGNING A WRITTEN REQUEST AND PAYING THE REQUIRED FEES. I UNDERSTAND REQUIRED INFORMATION WILL BE DISCLOSED IF I AM DIAGNOSED WITH A CONDITION THAT BY LAW REQUIRES REPORTING A HEALTH DEPARTMENT OR THE CENTER FOR DISEASE CONTROL AND PREVENTION.

WORKERS COMPENSATION: THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. SECTION - AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

Employer: _____ Phone: _____

* _____ **INDEPENDENT PHYSICIANS/PRACTITIONERS:** I UNDERSTAND DURING MY CARE I MAY BE TREATED BY INDEPENDENT HEALTHCARE PROVIDERS, WHO WILL BILL ME INDEPENDENTLY FOR THEIR CHARGES AS ESTABLISHED BY SUCH PROVIDERS. I AGREE THAT FACILITY IS NOT RESPONSIBLE FOR, NOR DOES FACILITY ASSUME ANY LIABILITY FOR THE ACTIVITIES OF SUCH HEALTH CARE PROVIDER OR ANY OTHER SUPPLIER OF CARE SERVICE WHO IS NOT AN EMPLOYEE OF THE FACILITY.

* **PATIENT PORTAL:** BLOUNT MEMORIAL HOSPITAL OFFERS A PATIENT PORTAL WHICH ALLOWS A PATIENT (OR DESIGNEE) TO SET UP A SECURE USERNAME AND PASSWORD TO ACCESS THEIR MEDICAL RECORDS THREE DAYS AFTER DISCHARGE. IF YOU WISH TO PARTICIPATE YOU MUST PROVIDE AN EMAIL ADDRESS. BY SUPPLYING THE EMAIL ADDRESS AT THE TIME OF REGISTRATION, I ACKNOWLEDGE THAT MY MEDICAL INFORMATION WILL BE ABLE TO BE ACCESSED THROUGH PATIENT PORTAL AFTER I (OR WHO I ALLOW ACCESS TO MY EMAIL) RESPOND TO THE INVITATION TO PARTICIPATE IN PATIENT PORTAL AND CREATE MY OWN UNIQUE PASSWORD. I ALSO ACKNOWLEDGE THAT I AM RESPONSIBLE FOR WHOM I ALLOW ACCESS TO THIS INFORMATION.

Email Address: _____ Owner Name: _____

* **MEDICATION AND MEDICAL DEVICE ASSISTANCE PROGRAM:** IN SOME CASES, THE HOSPITAL MAY BE ABLE TO OBTAIN REIMBURSEMENT FOR SOME OF YOUR MEDICATIONS OR MEDICAL DEVICES FROM COMPANIES THAT MANUFACTURE THEM. IN THE EVENT THIS OCCURS, THE CHARGE FOR THE MEDICATION OR MEDICAL DEVICE IS REMOVED FROM YOUR BILL FOR THAT HOSPITAL STAY. MOST OF THESE PROGRAMS REQUIRE YOUR SIGNATURE ON THE APPLICATIONS FORMS. IN ORDER TO AVOID YOU HAVING TO SIGN THIS APPLICATION FOR EACH MEDICATION OR DEVICE, WE ARE REQUESTING THAT YOU ALLOW A PHARMACY HEALTHCARE SOLUTIONS (PHS) REPRESENTATIVE TO SIGN THESE FORMS ON YOUR BEHALF. I APPOINT PHS TO CARRY OUT IN MY NAME, THE APPLICATION FORMS REQUIRED FOR PHS TO OBTAIN REPLACEMENT OF MY MEDICATIONS OR MEDICAL DEVICES FROM MANUFACTURERS. THE BELOW SIGNATURE WILL BE ACTIVE FROM DATE SIGNED.

[ ] I DO NOT WISH TO PARTICIPATE

* **PHOTO IDENTIFICATION REQUIREMENT:** WE REQUEST A PHOTO OF YOU USED SOLELY FOR IDENTIFICATION PURPOSES. YOUR PICTURE WILL NOT BE DISCLOSED WITH MEDICAL RECORDS RELEASE WITHOUT YOUR CONSENT. IF YOU CANNOT PROVIDE PHOTO IDENTIFICATION, SUCH AS DRIVER'S LICENSE, WE WILL MAKE A DIGITAL PHOTO.

[ ] NO, I DO NOT AGREE TO HAVE MY PHOTO TAKEN FOR IDENTIFICATION.

---------- **HOSPITAL ONLY** ----------

* **INFORMATION / SWITCHBOARD CENSUS NOTIFICATIONS:**

I UNDERSTAND THAT MY NAME AND LOCATION MAY BE INCLUDED IN BMH'S PATIENT DIRECTORY. INFORMATION FROM THE DIRECTORY MAY BE SHARED WITH PEOPLE WHO ASK FOR ME BY NAME.

[ ] NO, DO NOT LIST ME IN THE PATIENT DIRECTORY. IF I GIVE OUT MY LOCATION AND NUMBER I UNDERSTAND THESE VISITS AND CALLS CAN NOT BE RE-ROUTED

I CERTIFY THAT I UNDERSTAND THIS CONSENT/RELEASE FORM AND AGREE TO ITS TERMS.

SIGNED: _____ **WITNESS:** _____

BY: _____ **DATE/TIME:** _____

RELATIONSHIP TO PATIENT: _____