MADISON COUNTY HEALTH CARE SYSTEM
An Affiliate of MERCYONE
300 W. Hutchings • Winterset, Iowa 50273
(515) 462-2373

AUTHORIZATION FOR TREATMENT AND CARE

AUTHORIZATION FOR TREATMENT AND CARE

I, the above named patient at Madison County Health Care System, hereby authorize the facility, treating physician and whomever he/she may designate as his/her assistants, to administer medical tests, diagnostic procedures, and perform treatment as considered therapeutically necessary. I hereby certify that I have read and fully understand the above Authorization for Treatment and Care. I also certify that no guarantee or assurances have been made as to the results of the treatment and care received at Madison County Health Care System.

I understand that there is currently a pandemic and that despite Madison County Health Care System's best efforts to protect me, I could be exposed to COVID 19 while in this facility.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby acknowledge the facility may furnish medical information about me without my consent or authorization so that the treatment and services I received from the facility may be billed to and payment may be collected from me, an insurance company, or a third party, including Title XIX (Medicaid) and Title XVIII (Medicare). The facility may also tell my health plan, insurance company, or third party payor about a treatment I am going to receive to obtain prior approval or to determine whether it will cover the treatment. I give permission for my family physician to receive a copy of my medical treatment. I request and authorize benefits be paid on my behalf.

RELEASE OF RESPONSIBILITY FOR VALUABLES

I hereby understand that Madison County Health Care System is not responsible for loss or damage to my personal valuables and personal property (such as dentures, jewelry, glasses, garments, money, etc.)

FINANCIAL AGREEMENT/ AUTHORIZATION TO PAY INSURANCE BENEFITS

I, the undersigned, whether acting as an agent or patient, agree that in consideration for the services rendered or to be rendered do hereby assign payment directly to Madison County Health Care System, otherwise payable to me. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance coverage. I understand that I may be contacted regarding my healthcare, insurance coverage and in the collection of any unpaid portion of my bill using information provided by me which includes both residential and cellular phone numbers. THIS AGREEMENT IS IRREVOCABLE. Patient rights have been made available to me.

☐ **I have concerns about affording the care or prescriptions prescribed.**

PATHOLOGY SERVICES

Pathology services are medical services performed or supervised by Doctors and the personnel and facilities are or may be furnished by the hospital for said services. Charges for such services are or may be collected, however, by the hospital on behalf of said doctors pursuant to an agreement between doctors and the hospital, and from said charges I consent that an agreed sum will be retained by the hospital in accordance with an existing agreement between the doctors and the hospital.

PHYSICIAN ON SITE ACKNOWLEDGMENT

I am aware that Madison County Health Care System does not have a physician in the facility 24 hours per day. I understand that if an emergency medical condition develops while a physician is not on site, the staff will notify the physician on call and provide assistance according to established protocols.

PHONE AND EMAIL AUTHORIZATION

By providing us with your land line, cell phone number(s), and/or email address(s) you give consent for us, our agents, and our collection agents to contact you at these number(s)/address(s) or at any number(s)/address(s) that are later acquired by you. We may leave live or pre-recorded messages or texts regarding any accounts, services or survey details. For greater efficiency, an auto dialer may deliver calls or texts. However, providing us a telephone, cell number or email address is not a condition of receiving our services.

MADISON COUNTY HEALTH CARE SYSTEM
An Affiliate of MERCYONE
300 W. Hutchings • Winterset, Iowa 50273
(515) 462-2373

VIDEO SURVEILLANCE ACKNOWLEDGMENT

I understand the hospital has implemented video surveillance in inpatient rooms to assist it in monitoring patients. My signature below authorizes the hospital to utilize video surveillance to monitor my condition. I understand the video surveillance is not recorded and is for monitoring purposes only.

The undersigned certifies that he/she has read the foregoing, and acknowledges his/her understanding of its contents, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms.

☐ Advance Directive ☐ Patient Rights and Responsibilities

Signature: _____ Date / Time _____

Signee Relationship: _____

Witness: _____