Please print this form, sign it and return it, along with you insurance card and ID to MFMregistrationdocuments@virtua.org

PATIENT NAME: PATIENT AGE.

- ☐ 1. I am the patient named above
- ☐ 2. I am the parent or legal guardian of the patient
- ☐ 3. I am the legally designated representative of the patient (e.g.; in an Advanced Directive or a Medical Power of Attorney).
- ☐ 4. I am none of the above, but I have the following relationship with the patient

5. The patient named above is located in:
   - ☐ Virtua Mount Holly Hospital - 175 Madison Avenue, Mount Holly NJ 08060
   - ☐ Virtua Voorhees Hospital - 100 Bowman Drive, Voorhees NJ 08043
   - ☐ Virtua Marlton Hospital - 90 Brick Road, Marlton NJ 08053
   - ☐ Virtua Camden Hospital - 1000 Atlantic Avenue, Camden NJ 08104
   - ☐ Virtua Berlin Hospital - 100 Townsend Avenue, Berlin NJ 08009
   - ☐ Our Lady of Lourdes Hospital - 1600 Haddon Ave, Camden NJ 08103

NOTE: IF #4 above is checked, administrative notification may be required

READ THIS ENTIRE FORM BEFORE SIGNING IN PRESENCE OF THE WITNESS.
("I" refers to the patient named above or to the person signing the consent on the patient's behalf.)

CONSENT FOR TREATMENT

I authorize the medical staff, employees, and contracted healthcare providers of Virtua to provide necessary medical treatment to me, including routine laboratory tests, diagnostic procedures and medical care. I give consent to access all of my electronic medication information in connection with providing a list of current medications. Should a bloodborne exposure occur during this hospitalization, I consent to the drawing of blood for HIV testing. The results of this test will be placed in my medical record and protected in accordance with the applicable laws. In the event a physician, his/her assistants and designees determine that further treatment of my condition requires inpatient treatment, this consent shall serve as authorization for admission to Virtua. If the admission is due to maternity, the consent shall also apply to the admission and hospitalization of all newborn infants who are delivered by me during this hospitalization. Physician, nursing, mental health and other healthcare personnel who are in training may be observing and participating in my care under the supervision of Virtua staff and/or my physician, and Virtua uses telemedicine and camera technology for both patient treatment/care and security and I agree to the use of such technology. I hereby give my consent to such observations and/or participation. I agree that I am obligated to leave Virtua when medical services are completed.

PERSONAL VALUABLES

I understand that Virtua cannot provide continuous security to my personal property (money, jewelry, eyeglasses, radios, cell phones, any electronic devices or accessories including computers of any kind, IPAD, electronic readers, video games and MP3 players, etc.). Virtua, its trustees, officers, employees and agents are not responsible for loss of or damage to my personal property, unless I have given my personal property to Virtua for safekeeping. I understand that my valuable personal property should be sent home with either my family or a person whom I know well and believe to be trustworthy. IT IS RECOMMENDED THAT PATIENTS NOT KEEP MORE THAN $15.00 WITH THEM.

ASSIGNMENT OF BENEFITS AND GUARANTY OF PAYMENT

I assign to Virtua, and/or a Virtua based healthcare professional, all of my right, title and interest to medical and/or automobile insurance benefits and all other rights and benefits otherwise payable to me for those services provided at Virtua and/or by a Virtua based healthcare professional. I understand that Virtua may not be obligated to accept this assignment as payment in full. If my insuring company or agency refuses to pay any charges on the bill for whatever reason, I agree to be responsible for payment of fees, charges and costs associated with this Virtua service or stay to the extent allowed by law. If my insurer refuses to make a payment to Virtua or to any physician who provides care to me, I give my consent to Virtua and/or physicians who provide care to me to appeal the denial of payment.

MEDICARE/TRICARE (if applicable)

☐ Important Message from Medicare Notice given. ☐ Important Message from Tricare given.

FINANCIAL RESPONSIBILITY

I agree that, in consideration of the services to be provided, there is and shall be a continuing obligation to pay Virtua, and/or any Virtua based healthcare professional, for any medical services that are provided to me. I understand that Virtua's bill may not include certain physician services and that Virtua based physicians may bill separately for any medical services that are provided to me by them. I agree that I shall be responsible for all or any portion of unpaid charges incurred after payment of my Virtua bill by my insurer, except where I am eligible under Medicaid or another State or Federal program or as otherwise prohibited by law.

I understand and agree that if there are any health insurance deductibles, co-payments and/or co-insurance, that payment of these costs are my responsibility. I also understand that obtaining pre-certifications, referrals, second opinions, exclusions of 'pre-existing conditions,' and/or other requirements or conditions of my insurance coverage is ultimately my responsibility. I also agree that should the account be referred to an attorney or collection agency, I will pay reasonable fees associated with the collection of the unpaid charges.

I have reviewed information regarding availability of charity care programs.

RELEASE OF INFORMATION

I acknowledge receipt of the Virtua Joint Notice of Privacy practices. Initial:

I acknowledge receipt of the Health Information Exchange brochure. Initial:

I acknowledge being provided an opportunity to have a copy of my patient rights. Initial:

I acknowledge Virtua will discuss my discharge planning with my care partner. Your nurse will discuss your care partner with you upon admission.

I acknowledge that Virtua will release or disclose to any insurance company, governmental agency, managed care organization or any other entity or person who may be required to pay all or part of the costs of my treatment, hospitalization and/or outpatient care, all medical records or other information from Virtua records relating to my identity, diagnosis, prognosis and treatment. I understand that the specific type of information to be disclosed may include, but is not limited to diagnosis, discharge summary, history and physical, progress notes, doctors' orders, laboratory, operative and/or radiology reports, nurses notes, consultations and emergency department records. The purpose for this disclosure is to enable Virtua to secure payment of my Virtua bill from such insurance companies, governmental agencies, managed care organizations or other entities that may be required to pay on my behalf.

I agree, in order for Virtua to service my account to collect any amounts owed, Virtua may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Virtua may also contact me by sending text messages or e-mails, using any e-mail address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

MEDICAL RECORD RELEASE FOR EMERGENCY DEPARTMENT TREATMENT

My medical record of this Emergency Room visit will automatically be sent to the family physician I have identified unless "DO NOT" is checked.

☐ I DO NOT authorize the release of my medical record information to my Family/Primary Physician whose name I have provided.

If you have any questions or concerns, please let us know.

I acknowledge and agree to all the above terms:

SIGNATURE OF PATIENT OR PERSON SIGNING ON PATIENT'S BEHALF

Name of individual signing form:

Witness Signature

SIGNATURE OF FIRST WITNESS

First Witness Name:

☐ Signature(s) were unable to be obtained by the patient, or the person signing on the patient's behalf. Verbal consent was received by the parent/guardian, legally designated representative, or other individual, and two witnesses attest to these verbal consents and agreements.

SECOND WITNESS

Second Witness Name: