LEHIGH VALLEY HOSPITAL
LEHIGH VALLEY HOSPITAL-HAZLETON
LEHIGH VALLEY HOSPITAL-POCONO
LEHIGH VALLEY HOSPITAL-SCHUYLKILL
LVHN SURGERY CENTER-TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
LEHIGH VALLEY PHYSICIAN GROUP (All Practices)
LVHN-EAST STROUDSBURG AMBULATORY SURGERY CENTER
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH ALLENTOWN
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH BETHLEHEM
LEHIGH VALLEY HEALTH NETWORK REHABILITATION CENTER-SCHUYLKILL
LVHN COORDINATED PROFESSIONAL PRACTICE (All Practices)

Name: _____

DoB: _____

LEHIGH VALLEY HEALTH NETWORK CONSENT FOR TREATMENT

Please note that this consent applies to services rendered at, or rendered virtually by, the following Lehigh Valley Health Network (LVHN) entities: Lehigh Valley Hospital, LVHN Surgery Center-Tilghman, LVHN Children's Surgery Center, LVHN-East Stroudsburg Ambulatory Surgery Center, Lehigh Valley Hospital-Hazleton, Lehigh Valley Hospital-Pocono, Lehigh Valley Hospital- Schuylkill, Lehigh Valley Hospital-Coordinated Health Allentown, Lehigh Valley Hospital-Coordinated Health Bethlehem, Lehigh Valley Health Network Rehabilitation Center-Schuylkill, Lehigh Valley Physician Group and LVHN Coordinated Professional Practice and all its medical practices.

1.) **CONSENT FOR TREATMENT:** I grant authorization to LVHN and all its physicians and staff whether employed directly by LVHN or brought in on a consulting basis, for all such treatment and procedures as may be necessary for the patient herein named in accordance with the judgment of the medical provider. I understand that I am responsible for providing complete and accurate information concerning my medical history and current condition to my physician(s) and other health care providers. I understand that LVHN utilizes telehealth/ telemedicine technologies including digital photography, interactive audio and/or video, cloud-based storage and other types of secure HIPAA compliant technologies. Photographs, interactive video, and/or audio may be taken and/or utilized during my stay for treatment reasons or for monitoring my safety. Photographs may become part of my medical record, as appropriate. I acknowledge that no guarantees have been made as to the results of treatments or examinations in LVHN, or otherwise. I realize that I have the right to refuse any drugs, treatment, procedures or photographs to the extent permitted by law.

2.) **PAYMENT GUARANTEE:** I do hereby guarantee payment of all fees and charges incurred by and for the named patient from the date of admission/service, including services provided virtually. I agree to make payment in full immediately upon receipt of billings, whether interim or final billings. In the event that the undersigned fails to make payment as provided herein or agrees to alternate arrangements deemed satisfactory by LVHN, affirmative collection measures will be initiated. I agree to pay all costs of collection, including fifteen (15%) percent of the unpaid balance as a reasonable attorney's fees in the event that such indebtedness is turned over to an attorney for collection.

3.) **ASSIGNMENT OF BENEFITS:** In the event the undersigned is entitled to insurance benefits of any type out of any program health benefit plan or policy of insurance covering the patient or any other party liable to the patient, then such benefits are hereby assigned to LVHN and may be paid directly to LVHN. In the event benefits are paid, LVHN shall credit all payments to the patient's account; however, the patient and the undersigned, if not the patient, shall remain responsible for any portion of the LVHN bill not covered by this assignment. In the event that it is necessary to appeal an insurance payment decision, I authorize LVHN to appeal on my behalf.

4.) **INSURANCE COVERAGE NOTICE:** I acknowledge that LVHN will perform a search for active insurance coverage on all self-pay patients unless specifically requested otherwise with LVHN staff. This search will take place post-discharge, if named patient's bill remains unpaid for a defined period of time.

5.) **AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:** Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality, and to coordinate patient care across the provider network, avoiding duplication of services. LVHN has a system-wide electronic medical record that is available to caregivers, on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated Lehigh Valley Physician Group and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. LVHN and/or the treating physician can furnish and release to federal and state healthcare oversight agencies or upon written request, to all insurance companies or their representatives, any information with respect to treatment of the patient herein named including copies of the medical record.

6.) **HEALTH INFORMATION EXCHANGES:** LVHN may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through *Care Everywhere*® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with an HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases. **IF YOU ARE NOT INTERESTED IN HAVING YOUR HEALTH INFORMATION SHARED WITH OTHER HEALTH CARE PROVIDERS IN THE HIE, PLEASE CHECK THIS BOX.** ☐

7.) **PRIVACY NOTICE:** I acknowledge receipt of the Health Information Privacy Notice for LVHN and the LVHN Medical Staffs on or after April 14, 2003, and as amended from time to time.

8.) **MEDICAL ASSISTANCE VERIFICATION:** I certify that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

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9.) **TELEPHONE CONSENT:** I agree to allow LVHN, its agents, and vendors to use pre-recorded or artificial voice messages, or an automatic telephone dialing system, to contact me at the phone numbers that I provided and are on file (including wireless or cell phone numbers), and to leave voice mail messages at these phone numbers and include in any such messages information (including information required by law) about experience outreach and amounts I owe. **IF YOU REFUSE TO PROVIDE TELEPHONE CONSENT, PLEASE CHECK THIS BOX.** ☐ Please note that this provision does not affect the ability of LVHN providers to leave messages regarding appointment reminders or treatment information.

10.) **ELECTRONIC PRESCRIBING:** I understand that LVHN medical practices and offices may use an electronic prescription system which allows prescriptions and relates information to be electronically sent between my LVHN providers and my pharmacy. I have been informed and understand that LVHN providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my LVHN providers to see this health information.

11.) **IMMUNIZATION REGISTRY:** I understand that LVHN participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

In addition to the Terms and Conditions set forth in Paragraphs 1 through 11 above, the following also applies to services rendered at, or rendered virtually by, LVHN Hospitals:

AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION: As a patient, I have the option to be listed in the LVHN public information directory. If I elect not to be listed ("Do Not Announce") my presence will not be acknowledged and mail, telephone calls, flowers and visitors will be refused. Being listed in the public information directory means that your room number, telephone numbers and general condition can be released in matter of public record.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I understand and have been made aware that the Hospital provides facilities for the safekeeping of valuables. I release the Hospital from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in the patient's room, or at the bedside, including those valuables that may be brought to the patient by other persons.

DATA COMPILATION FOR RESEARCH: The undersigned hereby grants authorization for the Hospital to use a patient's health information for the internal purpose of gathering and sorting data (or human tissue) by categories to be available for potential use in research studies. If a patient's information is to be used for a research study, patient may be asked to sign additional authorization at that time.

PATIENT RIGHTS: I hereby acknowledge receipt of information regarding Patient Rights and the complaint process. I understand that I may contact the Department of Health at 800-254-5164 or the Joint Commission, Office of Quality & Patient Safety at: jointcommission.org/resources/patient-safety-topics report-a-patient-safety-event or Fax: 630-792-5636 if I want to report concerns about patient safety and quality of care. I understand that I may have a copy of the patient rights upon request.

In addition to the Terms and Conditions set forth in Paragraphs 1 through 11 above, the following also applies to services rendered at, or rendered virtually by, Lehigh Valley Physician Group (LVPG) and LVHN Coordinated Professional Practice (LCPP) practices:

LVHN EMPLOYEE IMMUNIZATION RELEASE: If you are employed by an LVHN subsidiary, I agree that vaccination documentation can be transmitted to LVHN Employee Health to facilitate any healthcare I may receive regarding occupational exposures or injuries and to verify that I meet vaccination requirements.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all LVPG and LCPP medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release LVPG/ LCPP from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a medical practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for LVPG/ LCPP to send or fax childhood immunization records to schools, upon request.

ACKNOWLEDGMENT FORM: I certify that I have read this document, that it has been fully explained to me if requested and that I understand its contents, and hereby agree to all terms and conditions set forth in the paragraphs above and acknowledge receipt of a copy if requested.

Signature of Patient	Date	Time
Signature of Authorized Agent / Representative	Date	Time
Relationship to Patient		
Witness	Date	Time

Lehigh Valley Physician Group
Medical Consent Authorization for Minor

(Giving permission for other person to bring my child to appointments and/or to make medical decisions for minor child on my behalf)

I, _____ am the **PARENT** of the child(ren) listed below. There are no court orders now in effect that would keep me from giving permission to another person (listed below) to make medical decisions (in other words, "medical consent") for my child.

—OR—

I, _____ am the **LEGAL GUARDIAN** or legal custodian of the children listed below (copy of court order attached, if available). There are no court orders now in effect that would keep me from giving permission to another person (listed below) to make medical decision (in other words, "medical consent) for this child.

I, _____, do hereby confer upon the following individual(s) the power to consent to medical or mental health treatment for the child(ren) listed below and on the child(ren)'s behalf do hereby state that the power to consent to which I confer shall not be affected by an subsequent disability or incapacity.

Individuals:*I give the following individuals permission to make medical decisions* (example: grandparents, siblings, etc.)

Name	**Address**
_____	_____
_____	_____
_____	_____
_____	_____

For Child(ren):

Name	**Date of Birth**	**Address**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- The power which I confer is specifically limited to health care and mental health care decision-making and it may be exercised only by the person's above.
- The person(s) named above may consent to the child(ren's) (**cross out any that do NOT apply**) ***medical, dental, surgical, developmental, and/or mental health*** examination and treatment. The person(s) named above may have access to any and all records, including, but not limited to insurance records regarding any such services.
- I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result of pressure, threats, or payments by any person or agency. ***This document shall remain in effect until I notify the child(ren)'s medical, dental, mental healthcare and insurance providers and the person(s) named above in writing of my wish to revoke it.***

I, _____, have signed my name to this medical consent authorization, consisting of (1) page, on this _____ day of _____, 20_____ in _____, PA.

_____ _____

Printed name (Parent, legal guardian/custodian) ***Signature***

Witness No 1: Print name and Address: _____

Witness No 1: Signature _____

Witness No 2: Print name and Address: _____

Witness No 2: Signature _____

Signature(s) of person(s) authorized to consent on behalf of child(ren) named above (if available):

_____ _____

_____ _____