Comanche County Hospital Authority
Lawton, Oklahoma 73505

Admission Consent/Release

COMANCHE COUNTY HEATHCARE AUTHORITIES (CCHA)

Includes Comanche County Memorial, Memorial Medical Group (MMG) and Community Health Centers and Cancer Centers of Southwest Oklahoma.

AUTHORIZATION FOR MEDICAL TREATMENT

CCHA and its Medical Staff are hereby authorized to administer any medical, diagnostic or therapeutic treatment, including blood transfusions, as may be deemed necessary or recommended by my physicians during my admission. I understand that my care team may include resident physicians and students or other trainees. I will be given the opportunity to consent or to refuse consent to any specific proposed procedure or therapeutic course of action, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are created and retained by CCHA and are accessible to hospital personnel and Medical Staff members during and after my admission. My electronic medical information may be accessed by other healthcare practitioners who treat me. Hospital personnel and physicians involved in my care may use and disclose medication information for hospital operations and functions and may disclose that information to their physicians or healthcare personnel involved in my continuum of care. Safeguards are in place to discourage improper access to my information. CCHA and its Medical Staff are authorized to disclose all or part of my medical information to any insurance carrier, workers compensation carrier, or self-insured employer group that is responsible to pay for any part of CCHA's charges. The information I authorize you to release may include mental health and/or substance abuse treatment information. This authorization to disclose my information for payment purposes will expire after CCHA is paid in full for my care. This authorization for disclosure may be revoked in writing at any time by contacting the Privacy Officer listed in the CCHA Notice of Privacy Practices. The revocation will not apply to information that has already been released or disclosures required by state or federal law. The entities to whom your information is disclosed could disclose it with others and it would no longer be protected by law. I understand if I revoke the authorization to release information to my insurance company. I will be responsible to pay for incurred charges.

RELEASE OF RESPONSIBILITY

CCHA is hereby released from any responsibility for the loss or damage to any items of personal property I do not provide to it for safekeeping. CCHA is held harmless from any injuries, damages claims or actions which may arise out of my use of personal electrical equipment that I bring to the hospital.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance benefits that cover the charges of CCHA for my care are hereby assigned to CCHA. I further agree that any insurance benefits that cover my Physicians charge for my care are hereby assigned to the physician or physicians that provided my care. Any payment received by CCHA or my physicians for my care may be applied to any unpaid bills for which I am responsible, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

I understand that CCHA will assist me with insurance precertification/preauthorization requirements that are the responsibility of the policy holder and/or physician. However, CCHA will not assume responsibility for obtaining precertification or for any impact the precertification may have on the amount of insurance coverage provided by my insurance carrier.

FINANCIAL RESPONSIBILITY

In consideration of the services provided to me by CCHA, I hereby guarantee payment for any amount due for such services. Hospital and physician charges for services and goods shall be at CCHA's billed charges rates unless otherwise agreed in writing by CCHA. The full amount of these charges or my deductible or co-payment amount under my insurance plan is due at the time of service or when I am discharged from the hospital. Non-covered charges are due at the time of services or discharge even if my insurer denies coverage because it believes that CCHA charges are different from the usual and customary charges that the insurance company has set. I understand that it is my duty, or that of my representative, to ask about and understand the coverage provided by my insurance company, and that the insurance company alone determines how much of the CCHA or other provider charges that it will pay. I understand that my insurance plan may not cover all of the services, supplies, or physicians involved or used in my care. I understand that I may receive additional provider bills for interpretations or services render to include but not limited to pathology, radiology, laboratory, emergency physician services and anesthesia. I consent to the hospital and its agents, including debt collectors, calling me at the telephone number(s) that I provide or that are associate with me, including use of auto calls, to verify my account or to collect amounts I may owe to CCHA or its providers. I consent to the hospital and its agents, including debt collectors, contacting me via phone call, email, SMS, auto dialing, pre-recorded messaging and use of artificial voice and artificial intelligence technology at the phone number that I provide or that are associated with me, including use of auto calls, to verify my account or to collect amounts I may owe to CCHA or its providers. I agree to be responsible for all attorney fees and court costs in collecting any sums due and owing for services received.

PATIENT RIGHTS AND RESPONSIBILITIES

I understand that as a patient I have rights and responsibilities and a copy of said rights and responsibilities has been made available to me.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement. I further certify that I am the patient or the legally designated representative of the patient authorized to accept the terms of this Patient Agreement. A photocopy or digital reproduction of this document has the same effect as an original.

Patient or Responsible Party _____ Date/Time _____ Relationship _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this facility is in our facility's NOTICE OF PRIVACY PRACTICES, which I have read before signing this agreement. I understand that a copy is included in my admissions packet and is posted throughout the hospital. My signature acknowledges that, I have received a copy of CCMH's Notices of Privacy Practices.

Patient or Responsible Party _____ Date/Time _____ Relationship _____

Witness (for entire form) _____ Date/Time _____
Basis for refusal, if refused: _____