TREATMENT AND BENEFIT AUTHORIZATION

Our Lady of Lourdes Regional Medical Center including its acute care, transitional care unit, rehabilitation unit, emergency department physicians, outpatient surgery, and outpatient departments, and is hereinafter referred to as "Hospital".

1. CONSENT FOR TREATMENT: I consent to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, hospital services, drugs and supplies, and/or other services rendered under the general and special instructions of my attending or consulting physicians. I understand that my treatment is under the control of my attending physicians, their assistants or designees. I recognize that most physicians furnishing services to the patient, include but are not limited to, the radiologists, cardiologists, pathologists, anesthesiologists, emergency department physician and the like are independent contractors and are not employees or agents to the medical center. I acknowledge that Lourdes provides nursing care for all its patients whether for acute, sub-acute (transitional care) or ambulatory care (Daytime or outpatient). I realize that in addition to employed hospital staff those who may attend patients at this hospital are medical, nursing, observers and other health care personnel in training who may be present during patient care as part of their education, which are supervised by qualified faculty and/or hospital staff, in accordance with the policies of the facility. If admitted, I understand that if I desire private duty nursing care, it is agreed that such must be arranged by myself or my family and the Hospital shall be released from any and all liability arising from such care. I understand that if further diagnostic studies or treatment procedures that are considered major in nature, such as an operation, are required, I will be asked to give specific consent prior to the study/procedure being carried out. I understand that the practice of medicine and surgery is not an exact science, and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. CONSENT TO DISPOSAL OF TISSUE/FLUIDS/SPECIMENS. I agree that the Hospital may utilize, destroy/dispose any tissues, fluids, or specimens taken from me during treatment.

3. AGREEMENT TO PAY FOR SERVICES: I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of the Hospital in accordance with its regular rates and terms. However, I am aware that any patient arriving at the facility will have a medical screening examination performed regardless of the ability to pay.

4. ASSIGNMENT OF INSURANCE BENEFITS:
   a. I hereby assign my insurance benefits otherwise payable to the undersigned and/or patient to be paid directly to the Hospital. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payment of all charges not covered by third-party payers. If I do not pay the amount due as I have agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.
   b. I hereby assign the insurance benefit otherwise payable to the undersigned and/or patient to any involved physician(s), including but not limited to radiologists, cardiologists, pathologists, anesthesiologists, emergency department physicians, and I authorize direct payment to said physicians of such benefits. I am responsible for charges not covered by this assignment.
   c. I understand that if my insurance carrier requires pre-certification, that, except in an emergency, it must be done prior to testing and/or admission to eliminate a reduction to my benefits. I also

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understand that when pre-certification is the responsibility of the patient and/or their physician, that any reductions to my benefits due to pre-certification not being obtained will be my responsibility.

d. NOTICE: Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

e. NOTICE: Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan, you may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for co-payments, coinsurance, deductibles, and non-covered services, specific information about in-network and out-of-network facility-based can be found at the website address of your health plan or by calling the customer service telephone number of your health plan.

5. PHOTOS: I consent to photographs, videotapes, digital or other images that may be recorded to document my care. I understand that these images may be used for case study and research. I understand that these images will be stored in a secure manner and will be released when requested for non-treatment reasons, only upon written authorization by me, or my legal representative. I consent to having part of my care be provided by use of video equipment, without the physician being physically present in my room.

6. AUTHORIZATION TO RELEASE INFORMATION:

a. I hereby authorize Our Lady of Lourdes Regional Medical Center, Inc., and hospital-based physicians rendering professional services to release any and all information, including medical records, social security number if required, and any and all other pertinent information pertaining to my admission and treatment in the said hospital as may be requested by any insurance company, manufacturer, employer, or any other agency which may have a concern or involvement with payment of charges, device tracking, or other genuine interest relating to hospital or professional services rendered to me.

b. I do hereby authorize Our Lady of Lourdes Regional Medical Center, Inc., to release any information before or after discharge, including medical history and physical or surgical treatment for this hospital admission, to any physician who will render care to the patient or any medical service organization requesting information after discharge.

7. AUTHORIZATION FOR HEALTHCARE RELATED CALLS, TEXTS, AND E-MAILS: I, the undersigned, hereby authorize and consent to the Hospital, its employees, agents, representatives, affiliates, business associates, and/or designees contacting me using prerecorded/artificial voice messages and/or automatic dialing services at any telephone number (including a wireless telephone) that I provide to the Hospital. This consent and authorization will apply to text messages sent to the wireless numbers I provide to the Hospital and also to e-mails using any e-mail address that I provide to the Hospital. This consent and authorization will apply to the current admission and any FUTURE admission to the Hospital. This consent and authorization is valid until revoked by me, in writing, by certified mail sent to the Hospital's address. If I am incapacitated and unable to provide my consent and authorization as discussed above, such consent and authorization may be given by any of those persons who are authorized to consent to surgical or medical treatment on my behalf pursuant to La. R.S. 40:1299.53. Such third party's consent and authorization, however, is only valid for the period of my incapacitation

MEDICARE/MEDICAID PATIENTS ONLY:

8. **ASSIGNMENT OF MEDICAL BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST: (Medicare/Medicaid Patients Only)** I certify that the information given by me in applying for payment under Title XVII or Title XIX of the Social

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Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I hereby assign and authorize payment of insurance benefits, otherwise payable to me, directly to Our Lady of Lourdes Regional Medical Center, Inc., for hospital services. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any applicable deductible and coinsurance, and non-covered charges, including personal charges.

9. MEDICARE/MEDICAID BENEFITS: I authorize the Hospital to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, and to any peer review organizations, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to the Hospital for services furnished to me, and to the physicians involved for their services, including those physicians/specialists doing their own billing, while I was a patient in the Hospital.

10. **ACKNOWLEDGEMENT OF MEDICAL REVIEW OF MEDICAL RECORDS**
(Medicare Beneficiaries Only)
As a hospital patient under the Medicare Program, your medical records may be reviewed to determine the medical necessity and appropriateness of the care provided during your hospital stay. Your medical records will be reviewed by the Louisiana Health Care Review, Inc. (LHCR), an organization of physicians authorized by the government to perform medical review of patient medical records to determine if the services and items provided during your hospital stay were reasonable, medical record may be retained for statistical purposes by LHCR.

    If LHCR decides, after reviewing your medical records, that the services and items provided during your hospital stay were not medically necessary, you and your physician will receive notification of this determination. You may file a request for a reconsideration of this determination by contacting the Hospital Business Office or by writing to the Louisiana Health Care Review, Inc. 8591 United Plaza Suite 270, Baton Rouge, LA 70809. Request for a reconsideration must be made within 60 days from the date you are notified of LHCR's determination.

11. MEDICARE/TRICARE PATIENTS ONLY: (only for acute care) I have received a copy of "An Important Message from Medicare/Tricare" and understand my rights as described in that document.

12. PERSONAL VALUABLES/BELONGINGS: I have ☐ elected ☐ refused (check one) to place valuables (i.e., money, jewelry, credit cards, or other articles of unusual value, etc.) into the Hospital's safekeeping during my period of hospitalization. Dentures, glasses, hearing aids, my garments and essential daily necessities are considered personal belongings. I understand that I am, at all times, responsible for the safekeeping of my personal belongings. I understand that the Hospital **CANNOT AND WILL NOT** accept responsibility for loss of any of my valuables/belongings, if they are lost or misplaced.

13. DENTURES: I understand that the Hospital provides denture cups for me if I require them. I will take precautions to be sure my dentures are properly kept and cared for and they will be kept in the denture cup at all times when I am not wearing/using them.

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14. **ADVANCED DIRECTIVES AND PATIENTS BILL OF RIGHTS. (Patient Self Determination Act)** Complete this section for acute, ambulatory surgery, observation and transitional care patients only.) **I acknowledge that I have been given information regarding this state's law on living wills and advance directives. Advance directives are documents such as living wills or powers of attorney for health care.**
    Please initial the following Applicable Statements:
    _____ I have executed a Living Will and have been requested to supply a copy to Lourdes.
    _____ I have reviewed the Living Will on file at Lourdes and it is my current copy.
    _____ I have not executed a Living Will.
    _____ I have received information about Advanced Directives as required by federal law.

15. Patient Information Booklet: I ☐ have received ☐ refused a Patient Information booklet/packet with the following information and understand that I can ask for help in understanding this information from my healthcare provider:
    Patient Bill of Rights & Responsibilities
    Personal Representative Designation Form ☐ Received ☐ Refused
    Medicare Message (Medicare Message for Medicare patients only)
    Your Safety & Security or Being a Partner in Healthcare Pamphlet
    Smoke Free Facility & Smoke Stopping Information

16. **Initial this _____ for outpatient non-surgical procedures**. This Agreement shall apply to any/all outpatient Non-surgical procedures provided during the twelve (12) month period from the date indicated below for the same diagnosis and service. **PATIENT/PERSONAL REPRESENTATIVE MUST COMPLETE BY SIGNING OR INITIALING.**

17. **CONSENT TO DISCLOSE GENERAL INFORMATION. I understand that my name, location in hospital, and general condition may be provided to any person asking about me by name, and to members of the clergy, my family, individuals involved in my health care, for disaster relief efforts, or as required by law. I do ☐ do not ☐ give consent for this information to be disclosed. Except as listed _____.**

_____
(Patient/Personal Representative Signature or Initial)

I certify that I have read and fully understand this document. I, as the patient/personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

_____ _____ _____ / _____ / _____
Patient / Personal Representative **Relationship to Patient** **Date**

_____ _____ / _____ / _____
Signature, Witness **Date**

_____ _____ / _____ / _____
Insureds Signature if not patient **Date**

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OUR LADY OF LOURDES REGIONAL MEDICAL CENTER
4801 AMBASSADOR CAFFERY PARKWAY, LAFAYETTE, LA 70508

Personal Representative Designation Form

The Health Insurance Portability and Accountability Act of 1996 gives you the right to have one or more persons act as your representative to make decisions about the uses and sharing of health information about you. This form tells us that you have named this person as your authorized personal representative. You can limit the amount of information that the authorized personal representative can decide about, and you can cancel this at any time. **Unless specified, this designation will expire upon discharge from this admission**.

DESIGNATION SECTION

I, _____ (print your name) hereby name the following person(s) to act as my authorized personal representative(s) with respect to decisions involving the use of and/or the sharing of health information that pertains to me.

Name:_____ Name:_____

Address:_____ Address:_____

Phone number:_____ Phone number:_____

Relationship to patient:_____ Relationship to patient:_____

VERIFICATION THAT PERSONAL REPRESENTATIVE MUST PROVIDE FOR PHONE INQUIRIES

Password or other unique identifier:_____

LIMITS TO THE AMOUNT OF INFORMATION - Please check one

- ❑ Financial and Demographic information only (billing records, address/phone number changes)
- ❑ Health care information only (health/illness information, HIV/AIDS status, Mental Health records, coordination of care, complaint resolution)
- ❑ Financial, demographic and health information
- ❑ Other_____

I understand that I may cancel this designation at any time by signing the revocation section of my copy of this form and returning it to the **Compliance Officer, 4801 Ambassador Caffery Parkway, Lafayette, LA. 70508.**

I understand that any cancellation can only apply to future disclosures or actions regarding my health information and cannot cancel actions taken or disclosures made while the designation was in effect.

_____ _____
Signature Date

Revocation Section

I no longer want this person to act as my personal representative.

Signature_____**Date**_____

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OUR LADY OF LOURDES REGIONAL MEDICAL CENTER
LAFAYETTE, LOUISIANA 70508

Personal Representative Designation Form

Form # *L90492*; New 9/03, 8/12

OUR LADY OF LOURDES
REGIONAL MEDICAL CENTER
Franciscan Missionaries of Our Lady Health System

Notice to Patients regarding Participating Provider Status

La. R.S. 22:1880

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES.

SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN.

1. Upon request you are entitled to receive a list that contains the name and contact information for each individual or group of hospital-contracted anesthesiologists, pathologists, radiologists, and hospitalists who provide services at the facility.
2. You may request information from your health insurance issuer as to whether those physicians are contracted with the health insurance issuer and under what circumstances you or the insured may be responsible for payment of any amounts not paid by the health insurance issuer.
3. For more information, please visit our website at www.lourdesrmc.com.

Based on the information I have provided at the time of my registration, I understand that Our Lady of Lourdes:

❑ Is a participating provider in my health plan.

❑ Is NOT a participating provider in my health plan.

❑ Is unable to confirm participating status under your third-party coverage with _____ on the date services are to be rendered.

_____ _____

Patient Signature Date

LOURDES IMAGING NETWORK

Primary Care Physician: _____

Name:_____

S.S. #_____ D.O.B _____

Mailing Address_____

City_____ State_____ Zip _____

Home Phone _____ Cell_____ **May we leave a message?** Yes No

Employer_____ Work Phone _____

Emergency Contact _____Relationship_____ Phone_____

Marital Status: S M D W **Race**: _____ **Hispanic** Yes No **Sex:** M F

Is this illness or injury due to an accident? **Yes** **No** If ***Yes***, what is the date the accident occurred? _____ What kind of accident **(select one)**: **Work** **Vehicle** **Other**

Guarantor/Insured Information

Primary Insurance: _____

Policy Holder: _____ Policy Holder's D.O.B. _____

Relationship to Patient: _____

Subscriber's Place of Employment: _____

Secondary Insurance: _____

Policy Holder: _____ Policy Holder's D.O.B. _____

Relationship to Patient: _____

Subscriber's Place of Employment: _____

Would you like to be enrolled in **MEDSEEK**, our online web portal to access your Medical Records?
If so, please provide your email address so we may send you an invitation to enroll: _____

I authorize the release of any medical information necessary for treatment by my current or future Physicians or healthcare providers I may be referred to. This authorization may also be used as consent to retrieve prior imaging studies or records from another facility/physician.

Sign _____ Date_____