

**Working Together to Serve the Community**

**This policy applicable to:**

- All Subsidiaries     All Hospitals  
 All Acute Care Hospitals

- BMRH  
 Mirmont Treatment Center

**ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**

**Subject: Authorization for Treatment and Release of Information Form**

**No. II.7**

**Policy**

This form provides a record of Consent for:

- Routine Hospital Service, Diagnostic Procedures and Medical Treatment
- Assignments of insurance benefits to Main Line Hospitals and/or physicians who hold staff privileges at the hospital.
- Release of information
- Authorization to file grievances with insurance companies, third party payors, case utilization and managed care review organizations.
- Forum selection
- Videotaping in the Observation Room of the Maple Unit at BMRH
- Personal Valuables

**Statement**

The Consent to Treatment and Administrative Authorizations” Form will be signed whenever a patient presents for emergency treatment, for admission as an Outpatient (for a procedure or surgery) or for direct admission. This form is not designed to take the place of, or to be used in place of the “Treatment Consent Form”, which is used to obtain informed consent for specific procedures and treatments. This consent form is executed by the patient or legally recognized representative. Those patients refusing to sign this form may still be treated.

Performed by Admissions, Registration or Nursing Personnel.

**Procedure**

1. The Consent to Treatment and Administrative Authorizations form is signed by the patient or legal representative as part of the admission or registration process. Staff inform patients that they are being asked to sign an authorization form and the purpose of the form. This form is authorization for treatment, release of information for insurance purposes, assignment of insurance benefits, and forum selection should the patient institute legal action related to his/her hospitalization and/or the medical services provided by the hospital or its employees or agents.
2. Patients are informed that their medical and demographic information will be shared throughout Main Line Hospitals with those who are involved with their care and treatment.
3. Patients who express a concern about having their medical and demographic information shared throughout Main Line Hospitals will be informed of our procedures to maintain the security of their information. These procedures are:
  - Main Line Hospitals routinely requires all employees to sign a patient confidentiality statement.
  - Violation of confidentiality may result in disciplinary action.
  - Main Line Hospitals has mechanisms in place to identify any breaches in patient confidentiality.
4. If the patient refuses to sign the consent form, services may still be provided and the refusal documented on the form.

5. Completion of the form may be delayed in emergency situations. Seeking services or emergency care constitutes an implied consent for routine healthcare services or lifesaving measures.
6. Minors less than 18 years of age and not emancipated cannot give consent for treatment. They must be accompanied by a parent, legal guardian or have written parental/guardian consent. Any minor may give consent for medical and health services to determine the presence of or to treat pregnancy, and/or venereal disease and other diseases reportable under the "Disease Prevention and Control Law" and the consent of no other person shall be necessary. Verbal consent may be obtained from the parent or legal guardian for outpatient services and must be documented by the registration staff. Telephone permission must be documented by two people who were present when consent was received.
7. Competent minors who are under the age of 18 and who meet any of the following criteria may also give consent:
  - Graduated from High School
  - Presently or previously married
  - Presently or previously pregnant
8. Patients 14-18 years of age can consent to admission to the Psychiatric Unit of BMH.
9. Competent adults are to consent for their own treatment. In the event the patient is physically unable to sign, verbal permission may be obtained and the circumstances documented on the consent.
10. If the patient is incompetent and unable to sign the consent, the patient's authorized representative may give consent.
11. If no one is available to sign, the treatment will be given in good faith. "No one available to sign" should be documented on the form and witnessed.

**Origination Date:** 2/98

**Previous Revision Date:** 2/99, 3/00, 9/01 10/02 9/10

**Review Date:** 1/03, 11/03, 11/06 11/07 11/08 11/09, 11/10 11/11

**Revision Date:** 11/11 RMH added; BMRH form added

**Key Contact:** Patient Access, System Director

Lakewood Medical Center  
Drews Manor Hospital  
Fossil Hospital  
Ridgely Hospital



CO0010

## **CONSENT TO TREATMENT AND ADMINISTRATIVE AUTHORIZATIONS**

### **1. Authorization for Treatment and Diagnostic Procedures:**

I voluntarily authorize, request and consent to inpatient/outpatient care and services, including diagnostic tests, procedures, examinations and medical treatment as ordered by my physician, his/her assistants, designees or other health care providers. I understand that the treatment ordered may require use of a range of medical devices and equipment, including but not limited to, intravenous (IV) lines, peripherally inserted central catheter (PICC) lines, urinary catheters and others. This consent extends and applies to Main Line Hospitals, its affiliates, and their agents, and employees including but not limited to physicians, residents, psychologists, nurses, therapists, healthcare assistants and other persons employed by or associated with the Hospital who may be engaged in my care and treatment. I understand that, except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

### **2. Release of Information (Including Medical Record Information):**

I authorize Main Line Hospitals to furnish health, demographic, and other information from my medical record to my insurance company, third party payors, case utilization and managed care review organizations which may be necessary in order for Main Line Hospitals to receive payment or obtain authorization for my care. I further authorize health, demographic, and other information from my medical record to be released to any health care provider, pharmacy, or institution providing health care, pharmacy or social services to me including, but not limited to, all Main Line Hospitals affiliates. Consent is also given for release of information to Main Line Hospitals by any insurer and all other agencies, pharmacies, institutions, or individuals from whom I have received or will receive medical, pharmacy or social services. This authorization does not apply to information specifically protected by state or federal laws or regulations.

### **3. Authorization to Pursue Grievances:**

I authorize Main Line Hospitals to file grievances with my insurance company, third party payors, case utilization and managed care review organizations which may be necessary to challenge denials of authorization or payment for a health care service. I understand that any medical care I receive is not premised on this authorization to file grievances and I understand that I may revoke this authorization allowing Main Line Hospitals to pursue grievances on my behalf at any time during the grievance process, by providing written notice to Main Line Hospitals. Finally, I understand that if Main Line Hospitals files a grievance to challenge denials of authorization or payment for health care services on my behalf, I will not be able to file a separate grievance on the same grounds.

### **4. Assignment of Insurance Benefits to Main Line Hospitals:**

I authorize payment of health care benefits directly to Main Line Hospitals including any Hospitalization or Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians, the hospital, and/or other providers, for services provided during my treatment. In making this assignment, I understand and agree that I may be financially responsible to Main Line Hospitals for charges not paid under my insurance policy(ies). I permit a copy of this authorization to be used in place of the original.

### **5. Assignment of Insurance Benefits to Physicians:**

I request that payment of authorized Medicare or other payor benefits be made either to me, or on my behalf, to the physician or supplier for any services furnished to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

6. **Advance Directives:**

I have a Living Will  Yes  No  
If yes, was copy provided  Yes  No

I have a Health Care Power of Attorney  Yes  No  
If yes, was copy provided?  Yes  No

7. **Claims:**

I agree that if I bring a claim or legal action of any kind that relates to my care or the medical services provided by Main Line Hospitals, its affiliates, employees or agents, I will file those claims or actions only in the courts of Montgomery County (Bryn Mawr Hospital and Lankenau Hospital), Chester County (Paoli Hospital), Riddle Hospital (Delaware County), Pennsylvania. I understand and acknowledge that the physicians providing services at Main Line Hospitals are not employees or agents of Main Line Hospitals or Main Line Health, Inc.

8. **Valuable and Personal Effects:**

Main Line Hospitals provides safekeeping services for money, personal belongings and other valuables. If I choose to keep any of these items in my possession, I do so at my own risk and I agree that Main Line Hospitals will not be responsible for their loss or damage.

9. **Photo Consent:**

I authorize Main Line Hospitals and its agents and employees to take or record photographs, videotapes, digital or other images of me for the purposes of treatment, identification, education within the institution, and documentation of my medical condition or course of treatment in the medical record. I am also aware that in certain clinical areas, videomonitoring may be utilized. I understand that in all instances patient confidentiality will be preserved.

I hereby certify that I have read and fully understand the above consent. I have had sufficient opportunity to ask whatever questions I might have and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its terms.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness



**1. Authorization for Treatment and Diagnostic Procedures:**

I authorize, request and consent to inpatient/outpatient services including diagnostic tests, procedures, examinations, and medical treatment as ordered by my physician, his/her assistants or designees, or other health care providers. This consent extends and applies to Bryn Mawr Rehab Hospital, its affiliates, and its agents, and employees including but not limited to physicians, psychologists, nurses, therapists, healthcare assistants and other persons employed by or associated with the Hospital who may be engaged in my care and treatment. I understand that, except in emergency situations, this consent does not include surgical or other procedures or treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of the procedures, treatment or examinations.

**2. Release of Information (Including Medical Record Information):**

I authorize Bryn Mawr Rehab Hospital to furnish information from my record to my insurance company, third party payors, and case utilization and managed care review organizations which may be necessary in order for Bryn Mawr Rehab Hospital to receive payment or obtain authorization for my care. I further authorize information to be released to any healthcare practitioner or institution providing healthcare or social services to me including all Bryn Mawr Rehab Hospital affiliates. Consent is also given for release of information to Bryn Mawr Rehab Hospital by any insurer and all other agencies, institutions, or individuals from whom I have received medical or social services. This authorization does not apply to information specifically protected by state or federal laws or regulations.

**3. Authorization to Pursue Grievances:**

I authorize Bryn Mawr Rehab Hospital to file grievances with my insurance company, third party payors, and case utilization and managed care review organizations which may be necessary to challenge denials of authorization or payment for a healthcare service. I understand that any medical care I receive is not premised on this authorization to file grievances and I understand that I may revoke this authorization allowing Bryn Mawr Rehab Hospital to pursue grievances on my behalf at any time during the grievance process, by providing written notice to Bryn Mawr Rehab Hospital. Finally, I understand that if Bryn Mawr Rehab Hospital files a grievance to challenge denials of authorization or payment for healthcare services on my behalf, I will not be able to file a separate grievance on the same grounds.

**4. Assignment of Insurance Benefits to Bryn Mawr Rehab Hospital:**

I hereby authorize payment of healthcare benefits directly to Bryn Mawr Rehab Hospital including any Hospitalization or Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians, the hospital, and/or other providers, for services provided during my treatment. In making this assignment, I understand and agree that I may be financially responsible to Bryn Mawr Rehab Hospital for charges not paid under my insurance policy (ies). I permit a copy of this authorization to be used in place of the original.

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**Bryn Mawr Rehab Hospital**  
Main Line Health

**5. Assignment of Insurance Benefits to Physicians:**

I request that payment of authorized Medicare or other payor benefits be made either to me, or on my behalf, to the physician or supplier for any services furnished to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits of the benefits payable for related services.

**6. Claims:**

I agree that if I bring a claim or legal action of any kind that relates to my care or the medical services provided by Bryn Mawr Rehab Hospital, its affiliates, employees or agents, I will file those claims or actions only in the courts of Chester County, Pennsylvania. I understand and acknowledge that the physicians providing services at Bryn Mawr Rehab Hospital are not employees or agents of Bryn Mawr Rehab Hospital or Main Line Health.

**7. Valuables and Personal Effects:**

Bryn Mawr Rehab Hospital provides safekeeping services for money, personal belongings, and other valuables. If I choose to keep any of these items in my possession, I do so at my own risk and I agree that Bryn Mawr Rehab Hospital will not be responsible for their loss or damage.

**8. Photo Consent:**

I authorize Bryn Mawr Rehab Hospital and its agents and employees to take or record photographs, videotapes, digital or other images of me for the purpose of treatment, identification, documentation and/or monitoring of my medical condition or course of treatment in the medical record. I am also aware that in certain clinical areas, video monitoring may be utilized. I understand that in all instances patient confidentiality will be preserved.

I agree to be videotaped for the management of behavioral issues in the Observation Room on the Maple Unit.

\_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Time**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Signature of Witness**

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# Bryn Mawr Rehab Hospital

Main Line Health

Attachment B – Outpatient Form

### 1. Authorization for Treatment and Diagnostic Procedures:

I authorize, request and consent to inpatient/outpatient services including diagnostic tests, procedures, examinations, and medical treatment as ordered by my physician, his/her assistants or designees, or other health care providers. This consent extends and applies to Bryn Mawr Rehab Hospital, its affiliates, and its agents, and employees including but not limited to physicians, psychologists, nurses, therapists, healthcare assistants and other persons employed by or associated with the Hospital who may be engaged in my care and treatment. I understand that, except in emergency situations, this consent does not include surgical or other procedures or treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of the procedures, treatment or examinations.

### 2. Release of Information (Including Medical Record Information):

I authorize Bryn Mawr Rehab Hospital to furnish information from my record to my insurance company, third party payors, and case utilization and managed care review organizations which may be necessary in order for Bryn Mawr Rehab Hospital to receive payment or obtain authorization for my care. I further authorize information to be released to any healthcare practitioner or institution providing healthcare or social services to me including all Bryn Mawr Rehab Hospital affiliates. Consent is also given for release of information to Bryn Mawr Rehab Hospital by any insurer and all other agencies, institutions, or individuals from whom I have received medical or social services. This authorization does not apply to information specifically protected by state or federal laws or regulations.

### 3. Authorization to Pursue Grievances:

I authorize Bryn Mawr Rehab Hospital to file grievances with my insurance company, third party payors, and case utilization and managed care review organizations which may be necessary to challenge denials of authorization or payment for a healthcare service. I understand that any medical care I receive is not premised on this authorization to file grievances and I understand that I may revoke this authorization allowing Bryn Mawr Rehab Hospital to pursue grievances on my behalf at any time during the grievance process, by providing written notice to Bryn Mawr Rehab Hospital. Finally, I understand that if Bryn Mawr Rehab Hospital files a grievance to challenge denials of authorization or payment for healthcare services on my behalf, I will not be able to file a separate grievance on the same grounds.

### 4. Assignment of Insurance Benefits to Bryn Mawr Rehab Hospital:

I hereby authorize payment of healthcare benefits directly to Bryn Mawr Rehab Hospital including any Hospitalization or Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians, the hospital, and/or other providers, for services provided during my treatment. In making this assignment, I understand and agree that I may be financially responsible to Bryn Mawr Rehab Hospital for charges not paid under my insurance policy (ies). I permit a copy of this authorization to be used in place of the original.

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# Bryn Mawr Rehab Hospital

Main Line Health

### 5. Assignment of Insurance Benefits to Physicians:

I request that payment of authorized Medicare or other payor benefits be made either to me, or on my behalf, to the physician or supplier for any services furnished to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits of the benefits payable for related services.

### 6. Advance Directives:

I have a living will:  Yes  No

If yes, was copy provided?  Yes  No

I have a Health Care Power of Attorney:  Yes  No

If yes, was copy provided?  Yes  No

### 7. Claims:

I agree that if I bring a claim or legal action of any kind that relates to my care or the medical services provided by Bryn Mawr Rehab Hospital, its affiliates, employees or agents, I will file those claims or actions only in the courts of Chester County, Pennsylvania. I understand and acknowledge that the physicians providing services at Bryn Mawr Rehab Hospital are not employees or agents of Bryn Mawr Rehab Hospital or Main Line Health.

### 8. Valuables and Personal Effects:

Bryn Mawr Rehab Hospital provides safekeeping services for money, personal belongings, and other valuables. If I choose to keep any of these items in my possession, I do so at my own risk and I agree that Bryn Mawr Rehab Hospital will not be responsible for their loss or damage.

### 9. Photo Consent:

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I agree to be videotaped for the management of behavioral issues in the Observation Room on the Maple Unit.

\_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Time**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Signature of Witness**

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