

Walton Rehabilitation Health System

1355 Independence Drive
Augusta, Georgia 30901-1037
(706) 724-7746

(Addressograph)

Certification of Information: I certify the information given during preadmission is true, accurate, and complete.

Consent for Treatment: I authorize and consent to treatments at Walton Rehabilitation Healthcare System (WRHS), Augusta, Georgia including, but not limited to, diagnostic procedures, local anesthesia, x-ray examinations, or treatments as may be needed and ordered or requested by the doctor in charge of this case, his assistants, designees or consultants. I authorize and consent to all other acts related to the procedures described above as may be necessary, appropriate or helpful to me for the reasons I have been admitted to the hospital. These acts include additional procedures judged needed or desirable by the doctor in charge of the case, his assistants, designees, or consultants.

Assignment of Hospital Insurance Benefits: I authorize payment of all hospital benefits, including major medical, Title XVIII Medicare, Title XIX Medicaid, and automobile insurance, which may otherwise be payable to me, to be paid directly to Walton Rehabilitation Health System, not exceeding the balance due of the hospital's regular charges for services and incidents. I am personally responsible to the hospital for charges not covered by these hospital benefits and any credit balance will be transferred to other hospital accounts for which I am responsible. I permit a copy of this authorization to be used in place of the original document.

Financial Responsibility: I agree to pay Walton Rehabilitation Hospital on demand all charges for services and incidentals incurred during my treatment at Walton Rehabilitation Hospital. I have read or had read to me the above guarantee and I understand fully that by signing my mark I become fully liable for the debt I incurred as a patient for services rendered by Walton Rehabilitation Hospital.

Release of Hospital's Responsibility for Loss or Damage to Personal Property: Walton Rehabilitation Health System is not responsible for loss or damage of personal items such as eye glasses, contact lenses, dentures or other special prostheses which I must wear while at the facility. The hospital is not responsible for replacing clothing items or other personal belongings I bring to the facility. I understand that jewelry, money and other personal items are my responsibility while on the hospital premises. I am encouraged to leave large amounts of money and valuables at home.

Authorization for Release of Medical Information

(Initial)

I authorize Walton Rehabilitation Healthcare System to release information to healthcare providers that have referred me to this facility or who may benefit from this information as they care for me in the future. I authorize the release of medical information, both now and in the future, to the commercial insurance firms and their utilization management agencies I named during registration, to my employer or any other agency who may be assisting in payment of my medical care, to the Center of Medicare Services and its intermediaries when establishing Medicare coverage, and to the appropriate Medicaid agencies in my home state if there is information in research where there is no patient identification. I authorize the release of my medical records from other health care providers to WRHS to assist in my care or the evaluation of my care. This release may include records of care rendered before or after my hospitalization at WRHS.

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I authorize my demographic information to be included on WRHS mailing lists so that I may receive communication regarding special events, patient care programs, patient satisfaction, publications, support groups, fund raising, or other hospital activities.

This authorization will expire in 90 days from the date of discharge.

According to the guidelines of the Federal Health Information Privacy Act, effective 04/03, healthcare professionals, using their best judgment, may disclose to a family member/relative, close personal friend and/or any other person **you** identify, health information relevant to that person’s involvement in your care or payment related to your care. A separate form will need to be completed for release of your medical record.

Please list those persons that you wish to receive information related to your care, including billing and appointment information:

Consent to be Included in Patient Location Reports *(Initial one of the following in this section.)*

_____ I consent to be included in the information system that includes name, location of treatment, and appointment information while I am in treatment at WRHS. I understand that this system is used to provide my location upon request to people such as, friends, and family. I also consent for my name to be posted on schedules, folders, and forms that may be located throughout the treatment area to assist staff in delivery of care.

_____ I do not consent to be included in the information system. I understand that this will mean that I cannot call to schedule or confirm appointments or communicate or provide completion times of treatment with transporters.

Acknowledgement of Receipt of Privacy Notice

(Initial)

I have received a copy of the Privacy Notice that went into effect on April 14, 2003. I consent to the uses and disclosures described in the notice. I understand that a detailed notice that further details my rights is available upon request.

- I am (check one):
- Patient
 - Parent of a minor patient
 - Legal guardian (Guardianship papers provided)
 - Durable Power of Attorney (Durable Power of Attorney provided)
- Other: _____

Signature

Date