St. Luke's Cornwall Hospital
A Member of the Montefiore Health System, Inc.

NAME: _____
ACCT: _____
MRN: _____
DOB: _____

GENERAL CONSENT FOR TREATMENT

CONSENT FOR MEDICAL TREATMENT AND ADMISSION: I hereby authorize ST LUKES CORNWALL NEWBURGH, and its practitioners, employees and agents (collectively, the "Hospital") to provide such care and administer such diagnostic, radiological, anesthesia, surgical, and/or therapeutic procedures and treatments as, in judgment of the Hospital, is deemed necessary or advisable in my (the patient's) care or (in the case of obstetrical patients) in the care of my newborn. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, withdrawal of blood for laboratory examination, and photographs taken to document my condition and/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 care and medical treatment.

This consent will apply to recurring treatment.

GUARANTEE OF PAYMENT: I agree to pay all amounts for which I am financially responsible, in accordance with the rates and terms of the Hospital. I understand that to the extent permitted by law, where insurance or other third party benefits are insufficient, I will be responsible for the payment of any balances due, including deductibles, copayments or other fees required by insurer or other benefit plan. I understand that if I have not provided the Hospital with accurate and current information regarding my (the patient's) insurer or other benefit plan/third party payor which provides me (the patient) with health care coverage, I will be personally responsible for the cost of all care rendered by the Hospital. I understand that the Hospital may require a consumer credit report in connection with the collection of an account. By signing this form, I am providing Hospital as well as its collection agency/attorney with a written authorization to obtain a consumer credit report. I agree to pay all bills when presented. Should the account be referred to an attorney for collection, I shall pay all reasonable attorney fees and collection expenses.

PHYSICIAN FEES: I understand that Physician fees are not included in the Hospital bill. The physician(s) involved in the care will bill directly for their professional services.

CREDIT BALANCE: I understand that credit balances which occur in my (the patient's) favor on this account may be applied by the Hospital to reduce any other outstanding account for which I am responsible.

AUTHORIZATION OF PAYMENT TO THE HOSPITAL: I authorize payment to the Hospital of all monies and/or benefits to which I (the patient) may be entitled from government agencies, insurance carriers or others who are financially liable for my (the patient's) medical care and treatment to cover the costs of care and treatment.

MEDICARE ASSIGNMENT: I understand that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize release of information needed to act on this request. I request that payment of authorized benefits be made in my (the patient's) behalf. I assign to the Hospital payment I receive for the unpaid charges of physician(s) for whom the Hospital is authorized to bill. I understand I am responsible for any deductibles, copayments and co-insurance under this act.

ACKNOWLEDGEMENT OF RECEIPT OF ADMISSION NOTICE: I have been offered and received:

- ○ YOUR RIGHTS AS A HOSPITAL PATIENT IN NEW YORK STATE
  Booklet given: ☐ **Yes** ☐ **Declined** ☐ **N/A**
- • BILL OF RIGHTS
  Booklet given: ☐ **Yes** ☐ **Declined** ☐ **N/A**

PERSONAL PROPERTY RELEASE FROM LIABILITY: I agree that the Hospital shall not be liable for loss, theft or damage to any personal property, including but not limited to: eyeglasses, dentures, hearing aids, money, cell phones and other personal effects that have been retained by me in my (the patient's) room.

I understand that valuables not deposited for safekeeping in the hospital's safe or ambulatory area locker at the time of admission shall remain my/the patient's obligation and responsibility. I hereby release the Hospital from any and all liability for all personal items that I (the patient) choose to retain in my (the patient's) room.

AUTHORIZATION TO CONTACT PATIENT: ST LUKES CORNWALL NEWBURGH uses third parties to help it with its billing, scheduling and customer satisfaction services. By signing this form, I consent to ST LUKES CORNWALL NEWBURGH and these third parties using my cell phone number and email address to send billing and payment statements, appointment reminders and customer satisfaction surveys to me with respect to the services I received from ST LUKES CORNWALL NEWBURGH.

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I authorize ST LUKES CORNWALL NEWBURGH to provide my contact information to these third parties only for these purposes. I agree that these third parties may contact me when necessary through phone calls, text messages, and emails to provide the above services. I understand that I do not have to sign this consent in order to receive health care services from ST LUKES CORNWALL NEWBURGH.

You have the right to request that we communicate with you about medical matters in a more confidential way or at a certain location. For example, you can ask that we only contact you by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

If my contact information changes or I wish to designate other communication preferences, I will contact the Hospital and provide updated contact information. I understand I may do so by calling, emailing, or mailing:

Montefiore Nyack Hospital	845-348-2000	Financialcounselors@montefiorenyack.org	160 North Midland Avenue, Nyack, NY 10960
Montefiore New Rochelle Hospital	914-365- 3812	NRFinancialAisstane@montefiore.org	16 Guion Pl, New Rochelle, NY 10801
Montefiore Mount Vernon Hospital	914-361-6899	MVFinancialAssitance@montefiore.org	12 N. 7th Ave, Mount Vernon, NY 10550
Burke Rehabilitation Hospital	914-597-2800	admitting@burke.org	785 Mamaroneck Ave, White Plains, NY 10605
White Plains Hospital Medical Center	914-681-1004	billing@wphospital.org	41 East Post Rd, White Plains, NY 10601
Montefiore St. Luke's Cornwall Hospital	845-568-2311	1Registration@montefioreslc.org	70 Dubois Street, Newburgh, NY 12550

I CONFIRM THAT I UNDERSTAND AND AGREE WITH THE EXPLANATION OR INFORMATION READ IN THE ABOVE CONSENT. I CONFIRM THAT I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS REGARDING HOSPITAL CARE AND ALL SUCH QUESTIONS, IF ANY, HAVE BEEN ANSWERED FULLY AND SATISFACTORILY. I CONFIRM THAT I HAVE READ THIS FORM IN ITS ENTIRETY AND FULLY UNDERSTAND ITS CONTENTS.

Patient/ Relative/ Guardian* Signature	**Print Name**	**Date**	**Time**
Interpreter (if required)	**Print Name**	**Date**	**Time**
Witness	**Print Name**	**Date**	**Time**

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is incompetent to sign.

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD