



**CONSENT FOR TREATMENT
AND AGREEMENT TO PAY
(ADULT)**

Inpatient / Outpatient

I. CONSENT FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Vanderbilt University Medical Center, including the administration of blood products. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). Further, I understand that should any hospital or emergency medical personnel, physician, or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Vanderbilt University Medical Center.

II. AGREEMENT TO PAY

I acknowledge and agree that I am responsible for and will pay for all regular charges, which are contained in the applicable VUMC pricelist ('chargemaster') which is in effect on the dates of services rendered, for items or services and treatment provided to me, including any amount not paid by my insurance plan. I understand that I can request additional information about charges for procedures, devices, pharmaceuticals, and other items or services, or can obtain a non-binding estimate prior, or subsequent, to signing this agreement.

I understand that some items or services that VUMC may provide to me may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services or items or services in excess of the limits in my member benefit agreement. Examples of items or services that may be deemed to be non-covered include cosmetic, transplant, certain durable medical equipment, personal convenience items, private nursing duty, sitter services, and certain medical supplies. I understand that I am personally responsible for any item or service determined by my third party payor (my insurance company) to be experimental, investigational, or to be non-covered for any other reason.

I understand that I am personally responsible for any non-covered Medicare, Medicaid, TennCare, or TriCare/CHAMPUS items or services that are listed on the financial responsibility for non-covered items or services form. I understand that I am personally responsible for deductibles and co-insurance established by my member benefit agreement, including those required for in-network laboratory and other ancillary services or items.

I hereby agree that if VUMC has agreed to bill my insurance or other third-party carrier, it has agreed to do so as a courtesy, and that VUMC has the right, should VUMC deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third-party carrier, unless VUMC and my insurance company or third-party carrier have agreed that I will not be billed.

I understand and agree that I have been advised that I may be billed by VUMC and that this Assignment of Benefits and Agreement to Pay applies to any and all VUMC physician services and both inpatient and outpatient VUMC hospital accounts. If a delinquent account referred for collection, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

III. ASSIGNMENT OF BENEFITS

I hereby authorize and request all insurance carriers, health maintenance organizations or managed care organizations with whom I have coverage, including TennCare, Medicare, Medicaid, and TriCare/CHAMPUS to pay directly to Vanderbilt University Medical Center, including Vanderbilt University Hospital, Vanderbilt University Children's Hospital, the Vanderbilt Medical Group and the Psychiatric Hospital at Vanderbilt ('collectively VUMC') any and all benefits due under the terms of my policy for items or services provided by VUMC, including any settlements or judgments for such items or services. If my health insurance will not allow direct payment to VUMC, I agree to immediately forward to VUMC all health insurance payments I receive for my care and treatment at VUMC.

Note: Patients receive and are exposed to further informational material prior to signing this form



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IV. GUARANTOR AGREEMENT - By signing in the space below as Patient/Legal Representative or Guarantor, I hereby agree that all charges connected with this treatment or any other treatment rendered to the above patient past or future, not covered by any insurance program, sponsorship or other third party coverage I may have are due and payable at the time of discharge or discontinuation of treatment. I understand that upon request I may be given a non-binding estimate of my hospital charges. I hereby acknowledge that if Vanderbilt University Medical Center has agreed to bill my insurance or other third party carrier, it has agreed to do so as a courtesy and that Vanderbilt has the right, should Vanderbilt deem it advisable, to demand payment in full from me at any time prior to full payment from any insurance or third party carrier, unless Vanderbilt and my insurance company or third party carrier have agreed that I will not be billed. I hereby acknowledge having been told that I may be billed by Vanderbilt and that this assignment and guarantor agreement shall be allowed to cover any and all accounts, including Vanderbilt physician accounts. If the delinquent account is referred for collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process.

V. Valuables Release (for inpatient and procedural areas only) - By signing in the space below as Patient/Legal Representative, I acknowledge that I have been given an opportunity to deposit valuables and money for safekeeping. I understand that the hospital assumes no responsibility for personal items or valuables retained by the patient.

VI. USE, RETENTION AND DISPOSAL OF TISSUE AND BLOOD

I understand and agree that any specimens or tissues normally removed from my body by VUMC in the course of any diagnostic procedures, surgery, or medical treatment that would otherwise be disposed of may be retained, used for educational purposes or research, including research on the genetic material (DNA) or other information contained in those tissues or specimens.

I acknowledge that such research by VUMC may result in new inventions that may have commercial value and I understand that there are no plans to compensate me should this occur, regardless of the value of any such invention.

I understand that any research using these leftover specimens or tissues will be done in a way that will not identify me or my medical information.

I also understand that if I do not want DNA research to be done using my leftover blood, I need to check the box shown below. If you have questions, please call 1-866-436-4710.

Do not use my leftover blood for the DNA Databank

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING.

Patient/
Legal Representative _____ Date _____ Time _____ A.M. P.M.

(Relationship to Patient) _____

Guarantor _____ Date _____ Time _____ A.M. P.M.
(If other than patient/legal representative)

Witness _____ Date _____ Time _____ A.M. P.M.

**COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL / ORIGINAL SIGNATURES
ON FILE IN THE HOSPITAL MEDICAL RECORD.**