Lexington Regional Health Center/Family Medicine Specialists/Medical Clinic/Elwood Clinic/Bertrand Clinic
Lexington, NE 68850/Elwood, NE 68937/Bertrand, NE 68927

CONDITIONS OF SERVICE

AUTHORIZATION FOR TREATMENT

1. Knowing that I am suffering from a condition requiring diagnosis and medical or surgical treatment, I do hereby consent to such diagnostic procedures and hospital care and to such medical surgical treatment as deemed necessary by my doctor or his designees.
2. I acknowledge that no guarantee has been made to me as to the result of treatment or examination in the hospital.
3. Any tissues or parts removed during surgery may be disposed of by Lexington Regional Health Center according to accustomed practice.
4. My use of any narcotics, drugs or medicine will be subject to Hospital and/or clinic control, and I agree that all such narcotics, drugs or medicines will be kept in the Hospital's possession to be dispensed in accordance with the hospital rules regulations.

CONSENT FOR TELEMEDICINE - I hereby consent to the use of telemedicine services including but not limited to e-Emergency or e-Hospitalist and other consultative services as ordered by my attending provider. I understand that the telemedicine provider will be at a different location from me. I can decline telemedicine services at any time without affecting my right to future care or treatment and any program benefits to which I would otherwise be entitled cannot be taken away. If I decline the telemedicine service alternatives will be discussed including but not limited to transfer to another facility. Lexington Regional Health Center personnel will use real time video to transmit or share necessary details of my medical history, examinations, x-rays, tests, photographs or other images with the telemedicine provider. Video or Audio during the consultation will NOT be recorded. The same confidentiality protections that apply to my other medical care also apply to the telemedicine service. I have access to all medical information resulting from the telemedicine consultation as provided by law.

TEACHING AFFILIATION - I understand that Lexington Regional Health Center and its entities are affiliated with various teaching institutions and I agree to participate in the education of health care professionals including but not limited to physicians and nurses. I agree to that at times, health care services can be delivered by students under the supervision of an attending physician or other authorized hospital personnel.

PHOTOGRAPHY - I understand that photographs, videotapes, digital, or other images may be recorded to document my care (this does not include telemedicine), and I consent to this. I understand that Lexington Regional Health Center and its entities will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Lexington Regional Health Center's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

AUTHORIZATION TO OBTAIN MEDICATION HISTORY - I authorize Lexington Regional Health Center and its entities to obtain/download my medication history from Pharmacies and/or Pharmacy Benefit Managers. This allows my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions.

AUTHORIZATION TO RELEASE IMMUNIZATION INFORMATION – I authorize Lexington Regional Health Center and its entities to exchange my immunization records with the Nebraska State Immunization Information System (NESIIS).

PRIVACY PRACTICE ACKNOWLEDGEMENT
I have received a copy of Lexington Regional Health Center and its entities' Notice of Privacy Practices. Version#____8_____

MEDICARE BENEFITS - Statement to Permit Payment of Medicare Benefits to Provider, Physicians, and Patients: I request payment of authorized Medicare benefits to be or on my behalf for any services furnished me by or in Lexington Regional Health Center and its entities including physician services.

FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS - The undersigned hereby assigns and authorizes payment to Lexington Regional Health Center, its entities, and the physicians, all hospital insurance benefits, including major medical, but not to exceed regular charges. The undersigned is financially responsible for charges not covered according to this assignment.

NON-COVERED ADMISSIONS - Some insurance plan have certain inpatient/outpatient hospital admissions which are excluded from coverage. If your medical chart indicates your admission is on for which no benefits are allowable, please be advised that all charges incurred during this confinement will be your financial responsibility.

PERSONAL VALUABLES - Lexington Regional Health Center does not assume responsibility for money, valuables, dentures, jewelry, glasses, and clothing kept in the patient's room, including ALL privately owned appliances. It is understood and agreed that the hospital maintain a safe for safekeeping of money and valuables, and the hospital staff shall not be liable for the loss of or damage to any money or other articles of usual value unless placed herein.

TELEPHONE NUMBER - By providing us with your landline or cell phone number(s), you give your consent for us, our agents, and our collection agents to contact you at these numbers or at any number that is later acquired for you, and to leave live or pre-recorded messages regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer. Providing us a telephone or cell number is not a condition of receiving our services.

I acknowledge that I have received a copy of my Patient Rights, including visitation rights, information regarding Lexington Regional Health Center's Payment and Advance Directive Policies, and Medicare/Champus information (when applicable).

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS:

I give LRHC and its entities permission to text my mobile phone and contact me via email. ☐ Yes ☐ No

Date & Time: ____

____
Patient/Personal Representative Signature

Witness: ____

____
Relationship to Patient

____
Patient Name/Label