DOS:

- l University of Kentucky A.B. Chandler Hospital
- l UK HealthCare Good Samaritan Hospital
- l UK HealthCare Ambulatory Services
- l UK Dental and Oral Health Clinics

AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

CONSENT TO TREATMENT: I consent to receiving medical care from the University of Kentucky. Medical care includes exams, testing, appropriate immunizations, medical treatment and treatment with controlled substances. I may be tested for HIV (the virus that causes AIDS), hepatitis and other diseases. My consent covers care from the agents, employees and medical staff of the University of Kentucky. No one has guaranteed me that the medical care will have certain results. I have the right (i) to make decisions about my health care, (ii) to refuse medical care, and (iii) to revoke this consent at any time except to the extent medical care has already been provided.

The patient or the authorized parent, guardian, responsible party or surrogate of the patient must give consent.

Images: I consent to let my health providers take and view images (such as photographs or video) for my care or identification. I understand and agree that some of these images may be retained while others are for real time monitoring only.

Teaching Institution: I understand that the University of Kentucky teaches and trains doctors, nurses and other health care providers (an academic medical center). Doctors in training (fellows, residents, interns, and housestaff), medical students and other medical trainees may be involved in my care with the appropriate supervision of my doctor.

Research: I understand that someone from the University of Kentucky may contact me in the future to ask me about my health or to take part in research.

ADVANCE DIRECTIVES: (Please check all statements that apply:)

- q I have signed Advance Directives (living will, health care surrogate declaration) and request that these directives govern my course of care, as much as possible under the law. I understand that I must provide the Hospital with a copy of my Advance Directives and that those directives will not govern any course of my care until they have been filed in my medical record.
  - q Advance Directives **attached**
  - q Advance Directives **not attached.**
- q I have not signed Advance Directives (living will, health care surrogate declaration), but I understand that I have the right to make decisions about my health care, including executing advanced directives.

FINANCIAL RESPONSIBILITY

Guarantee of Payment: I agree that I am responsible to the University of Kentucky and Kentucky Medical Services Foundation Inc. (KMSF) for charges resulting from services rendered at their prevailing rates. I agree that all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection cost or attorney fees resulting from the collection of my accounts. Neither the University of Kentucky nor KMSF in enforcing any rights shall in any manner release me or any responsible party of liability. If the undersigned is more than one person, this obligation shall be joint and several. I agree that the University of Kentucky or KMSF is not a party to any disputed claim or peer-review, which affects payment of any claim filed on my behalf and that upon request for payment from the University of Kentucky or KMSF; I agree to pay any outstanding balance. If any legal action should be sought by the University of Kentucky or KMSF in connection with the collection of charges resulting from services rendered, I agree to be subject to (and hereby consent to) the jurisdiction and venue of any such action or proceeding in the courts within the County of Fayette, Commonwealth of Kentucky, and that I agree to waive any objection that I may have based on improper venue or inconvenient forum. For collection purposes, I authorize UK HealthCare and all of its entities and 3rd party agencies, to contact me on my cell phone or any other phone which I have provided as my contact information, or any number assigned to me that is available to the public, using methods which include pre-recorded/artificial voice messages or the use of automated dialer. Furthermore, I authorize UK HealthCare and all of its entities and 3rd party agencies, to communicate with me at the e-mail address provided or through text messaging.

Assignment of Benefits: I hereby assign all rights and privileges and authorize payment directly to the University of Kentucky and KMSF for any claim filed on my behalf or on behalf of the person for whom I am duly authorized to sign for insurance benefits. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the University of Kentucky and KMSF for charges not covered by this assignment or not paid on a timely basis by the insurance company.

HealthCare

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AUTHORIZATIONS & AGREEMENTS

(Patient Label Here)

Certification: I certify that I have read and understand the consent and authorizations given above and that I am the patient or I am duly authorized by the patient to execute this document and accept its terms.

Rights and Responsibilities: I have received a copy of the Patient Rights and Responsibilities.

Advance Directives: I have received written information about Advanced Directives (Living Will).

NOTE: Interpretive services **must** be offered for preferred languages other than English.

X _____ _____

Patient Date / Time

X _____ _____

Signature of Legal Representative and Relationship to Patient Date / Time

_____ _____

Witness Date / Time

_____

Interpreter Name or ID# In person or via Cyracom (circle one)