syracuse AREA HEALTH
2731 Healthcare Drive
Syracuse, NE 68446
402.269.2011
syracuseareahealth.com

REQUEST AND CONSENT TO TREATMENT AND HOSPITAL CARE

I hereby request and voluntarily consent to medical examination and treatment which my attending doctor, his /her assistants, or Syracuse Area Health ("Hospital") personnel deem necessary and appropriate. I acknowledge that no guarantees have been made to me regarding the results of my Hospital treatment or examination. I understand that I have (or the patient has) the right to refuse treatment, and that my signature below is not a consent to any non-routine procedure. My doctor or Hospital staff may ask me to sign a form consenting to special medical or surgical procedures. I acknowledge that physicians and certain other practitioners providing services at the Hospital may be independent contractors, and not employees or

CONTINUING OUTPATIENT CARE

In some cases, proper treatment of a medical condition requires treatment over a course of repeated outpatient visits. In such cases, the request, consent, and agreements contained herein apply to all repeat visits and continuing treatment and diagnosis for the same condition.

PHYSICIAN COVERAGE

The Hospital is a critical access hospital and provides services to meet the health care needs of its patients through competent, fully trained staff who are available 24 hours a day. The Hospital does not, however, provide on-site physician coverage 24 hours a day, 7 days a week. I am aware that a physician is not present in the hospital 24 hours a day, 7 days a week. If a patient develops an emergency medical condition when there is not a physician on-site, qualified medical personnel will assess and treat the patient and contact the on-call physician.

PATIENT PORTAL

I understand that I may be offered access to the patient portal. The email address I provide will be used by Syracuse Area Health to send me an invitation and instructions on how to create a portal account and access my medical records through the online portal. I understand that I am responsible for anyone who may see my information because my email address is a shared email or I have given access to my email account to another person. I understand that I should keep my portal user name and password secure to prevent any unauthorized access to my information. If you suspect that someone has learned your password, you should access the portal site immediately and change it. If you suspect that an unauthorized person has access to your portal account, portal password, or if you suspect any other breach of security, you agree to immediately notify Syracuse Area Health's HIM Department at (402) 269-2011.

NeHII

Syracuse Area Health will make your protected health information available electronically to other health care providers and to payers through electronic health information exchanges. This lets us get information from records of other providers to better treat you, and lets other providers and payers get information from our records to treat you or pay claims. Your participation in these exchanges is optional. You can "opt-out" from NeHII by calling 866-987-1799.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the Hospital's current Notice of Privacy Practices:

☐ during this Hospital visit. ☐ during a previous Hospital encounter.

I have read this form (or have had it read to me) and understand it. I agree that by signing this form I am bound by what it says, whether I am the patient or someone acting on the patient's behalf.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY _____ DATE _____

WITNESS _____

PRINT NAME, IF SIGNED BY OTHER THAN PATIENT _____