UPH ST LUKES – CEDAR RAPIDS
1026 A Ave NE
Cedar Rapids, IA 52406-5036
Hospital: 319-369-7211

Consent for Treatment

- I agree to all nursing care, x-rays, tests and treatments done by hospital staff or doctors in the hospital.
- If I need more than one visit for my care, my consent is good for all visits

Results of Treatment
I know that care, tests, and treatments may have risks. These risks can be injury or even death. I, or someone responsible for me, understand that no guarantees have been made to me.

Drug and Alcohol Tests
Drug and alcohol tests might be needed to find out what is wrong and to treat me.

Release of Health Records for Payment
I agree to let the hospital give information about my care and treatment to:

- Health insurance companies,
- Health plans,
- Workers' compensation insurance companies and/or Employers,
- Other health programs that process and pay for the care and treatment given or,
- Other companies that agree to do work for these companies.

They need this information to know what payments to make to the hospital for my care and to find out if the hospital is allowed a discount under a United States law, Section 340B of the Public Health Service Act.
I agree that if I have testing for HIV/AIDS the hospital can give testing information, but not the test results, to the companies for payment.
This release is good until all the bills are paid.

Direct Payment to Hospital
For the health care services given to me, I agree payment can go directly to the hospital. This includes all payments to be paid for my health care and charges for the doctor services billed by the hospital. Payments may come from these sources but are not limited to:

- Primary and secondary health insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid, and CHAMPUS;
- Health plans such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations);
- Workers’ compensation or work related disease claims; and
- Money that I have gotten from a lawsuit or from settling a claim.

I know that I, or another person responsible for me, must pay the rest of the money that is not paid from insurance companies or other sources.

Insurance, Health Plan or Program Rules
I know that I need to follow all the rules of any insurance company or program that pays for my medical bills.
Rules can be these or others:

- Getting a second opinion from another doctor
- Calling the insurance company before having tests or treatments

If I do not follow the rules of the insurance company or program, they may not pay for my health care. I agree that I must pay for all bills not paid by the insurance company or program.

Agreement to File an Appeal on My Behalf

I know the level of care or medical need for services decided by my doctor may differ from that of my insurance company. My insurance company may deny payment for part of my hospital bill.

To help me if this happens, I agree the hospital can act for me to file a grievance or appeal the payment denial by my insurance company.

I agree to notify the hospital of the results of the grievance or appeal.

Pay Agreement

- I agree to pay the hospital on time.
- I know that I must pay the full amount for any and all bills that my insurance or program does not pay for.
- If I do not pay my hospital bill on time, I agree to pay other fair costs the hospital may have like collection bills, legal fees, and other costs.
- I know that if I cannot pay my bill, I can ask the hospital about a plan for helping patients who cannot pay their bills.

By providing us with your landline or cell phone number(s), I agree that:

- I give my consent for UnityPoint, their agents, and to their collection agents, to contact me at these numbers, or, at any number that is later acquired for me or anyone responsible for my account(s).
- I may be called by UnityPoint staff or collection agents who may leave live or pre-recorded messages regarding any accounts or services. For greater efficiency, calls may be delivered by an autodialer.
- I will receive health care services even if I do not provide any phone numbers.

Doctor Services

I acknowledge and understand that most physicians who provide physician services at UnityPoint Health are not employees or agents of UnityPoint Health, but instead are independent medical practitioners and independent contractors. I understand that each of these medical practitioners exercises his or her own, independent medical judgment and is solely responsible for the care, treatment, and services that they order, request, direct, or provide. I acknowledge that these practitioners are not subject to the supervision or control of UnityPoint Health and that the employment or agency status of physicians who treat me is not relevant to my selection of UnityPoint Health for my care. I also understand that I will receive, and am solely responsible for payment of, a separate bill from each of these independent practitioners, or groups of practitioners, for care, treatment, or services provided.

Agreement to Pay for Doctor Services

- I know that the doctor bills are separate from the hospital bills.
- I will get a separate bill from the doctors for their services.
- I agree to pay the doctor bills if my insurance or other program does not pay them, unless not allowed by state or federal law.

Doctor and Health Care Training

I understand that the hospital is a teaching hospital. This means there are doctors, nurses, and others who are in training at the hospital. As part of their training, they may help with my care, tests, and treatment.

Residents are licensed medical school graduates and are employees of the hospital that provides their training. As part of their training, they may help with my care, tests, and treatment.

Personal Property

- I understand my personal property may not be secure in my room or other care areas.
- I understand valuable items should be left at home or I should send them home.

Hospital Rules

I agree to follow all hospital rules, including the no smoking rule.

I have been given a brochure about my **Patient Rights and Responsibilities, Notice of Privacy Practices,** and **Advance Directives.**

Patient Signature _____ Date ____ Time ____

I do not want a brochure about my **Patient Rights and Responsibilities, Notice of Privacy Practices,** and **Advance Directives.**

Patient Signature _____ Date _____ Time ____

I agree the information I have given is correct:

- My Name
- Street address, City, State
- All phone numbers
- Insurance information
- All other information

Be sure you have your questions answered **before** you sign this form.

Patient Signature _____

Section for a Patient who is a minor, or is not legally able to sign.

Signature is from a person who has legal rights to consent for the patient.

Signature of Person_____
Legal Consent Relationship_____

Registrar Signature _____ Date _____ Time _____