

Central Vermont Medical Center

Admission/Medical Treatment Consent

MRN

Name

DOB

CONSENT TO ADMISSION AND MEDICAL TREATMENT: I have chosen to seek evaluation and treatment with Central Vermont Medical Center. I voluntarily consent to all care and treatment as necessary or proper, including emergency treatment, whether by Central Vermont Medical Center staff, the physician(s) assigned to me or residents and interns under the supervision of the physician assigned to me. I acknowledge and understand that the practice of medicine is not an exact science, and that no promises or guarantees have been made concerning the outcome or results of my care and treatment at Central Vermont Medical Center. I understand I can terminate my treatment at any time.

CONSENT TO RELEASE OF INFORMATION: I agree to allow Central Vermont Medical Center to release information regarding my medical treatment to any private or government insurance program that covers me, including Medicare or Medicaid as necessary to verify benefits, authorize services and process medical claims. In addition, release of medical records is authorized to a) my continuing care facility, b) any organization involved in planning my discharge or continuing care, c) any organization performing utilization review according to state or federal law.

CONSENT TO SPECIMEN USE: I authorize Central Vermont Medical Center to retain, preserve and use for scientific or teaching purposes, or to dispose of at its convenience, any specimens or tissues taken from my body during diagnosis or treatment.

PATIENT BILL OF RIGHTS: My signature on this form acknowledges my receipt of the Central Vermont Medical Center Bill of Rights.

CENTRAL VERMONT MEDICAL CENTER IS NOT RESPONSIBLE FOR PATIENT VALUABLES: Central Vermont Medical Center is not responsible for personal property, case, credit cards or other valuables left in Patient's room or elsewhere at Central Vermont Medical Center.

I have read and understand the information above, and I have had the opportunity to ask question and have them answered to my satisfaction. I certify that I accept the terms and conditions; or, is the patient or legal guardian of the patient, or is otherwise duly authorized as the Patient's agent to execute this Admission Agreement and accept its terms.

X _____
Signature of Patient or Guardian

X _____
DATE

TIME _____ AM _____ PM

X _____
Person Authorized to Consent for Patient

X _____
WITNESS

X _____
Relationship to Patient

TELEPHONE CONSENT RECEIVED FROM:

X _____
Name/Relationship

X _____
TIME

X _____
WITNESS

X _____
WITNESS

Forms Committee ID	TC-038
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