GENERAL CONSENT/ PERMISSION FOR TREATMENT FINANCIAL AGREEMENT

I authorize and consent to performance upon _____
(Insert "me" or Name of Patient)
by Hospital for Special Surgery (HSS) and its staff of such physical examinations, diagnostic imaging procedures (such as x-rays, CT scans, and/or magnetic resonance imaging (MRI)), laboratory tests, and other non-invasive diagnostic and therapeutic procedures and/or treatments, as my/the patient's physician or others on HSS's medical staff consider to be necessary or appropriate for the purpose of diagnostic and/or treatment of my/the patient's condition.

I understand that for each procedure/treatment the following will be explained to and discussed with me/the patient: the nature, intended purpose, anticipated benefits, material risks, and possible complications of such procedure/treatment; the alternative procedures/treatments if such procedure/treatment is not performed; and the probable consequences if such procedure/treatment or alternative procedures/treatments are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure/treatment may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I consent to the diagnostic study by HSS of any blood, urine or other bodily fluids, stool specimens, or tissues that are obtained in the performance of such procedures/treatments, and to the disposal of such fluids/ specimens/tissues by HSS in accordance with its customary practice. I further grant permission for HSS to use such fluids/specimens/tissues for medical, scientific and/or educational purposes.

I consent to the photographing, videotaping, televising, or other observation of the procedures/treatments as HSS or its surgeon(s)/physician(s) may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedures/treatments of a visitor or visitors, which may include any visiting physician(s) and/or vendor representative(s) whose presence has been requested by the above named surgeon(s)/ physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other HSS personnel, and subject to all relevant HSS policies and procedures.

I understand that information about me/the patient will be disclosed as required by applicable law, including reporting mandated by the federal, state and local governments to oversight agencies such as Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene. Examples of such mandated reporting include reporting of suspected or confirmed communicable diseases, child abuse, firearm wounds, and certain knife wounds and burns.

For patients age 19 and older only: I consent to the submission of information about my/the patient's immunizations to the New York Statewide Immunization Information System (NYSIIS), the New York City Citywide Immunization Registry (CIR), and any other federal, state or local immunization registry. I

Guarantee of Hospital Charges

I agree to be responsible for payment in full of the charges for all hospital services and other medical care rendered to me/the above-named patient for this period of care. I understand that even if I have/the patient has domestic or international health insurance coverage accepted by HSS, I will be responsible for payment in full of unpaid balances after insurance company payment to HSS, to the full extent permitted under federal, state and local laws. I understand that my responsibility also includes payment for charges not ordinarily covered by health insurance, such as private room charges.

Personal Property; Release of Liability

I understand that (i) I am solely responsible for any and all costs of items of personal property that I choose to keep with me and/or use while at HSS; (ii) HSS strongly recommends that I either send home or check with HSS Security Department all personal property of value to me, including but not limited to money, checks, jewelry, credit cards, and clothing; and (iii) any items of personal property that I leave behind after my discharge from HSS will not be HSS's responsibility; if HSS finds any items, they will be sent to the HSS Security Department (212-606-1207). I hereby release HSS and its medical staff members, employees and agents from any and all liability and claims arising from my keeping personal property with me while I am at HSS.

For Inpatients Only

Caregiver Designation

The New York State Caregiver Advise, Record and Enable Act, or CARE Act, provides that all inpatients who are 18 years old or older must be given the opportunity to designate a family member, friend, or other person to serve as a caregiver. The role of the designated caregiver is to assist with after-care tasks when the patient is discharged to the patient's home. Most often this will include information about the medications you will be taking at home, how you might need help in moving, with exercises or with managing pain, and information about your surgical site and appointments after discharge. The CARE Act requires that hospitals notify the designated caregiver of the expected discharge or transfer of the patient, and instruct the designated caregiver regarding after-care tasks that are part of the patient's discharge plan. A patient may change his/her designated caregiver(s) at any time.

_____ I do not consent to the release of my medical information by HSS and its staff to my designated caregiver(s).
(Initial)

I confirm that I have read and fully understand this General Consent/Permission for Treatment & Financial Agreement, that I have been given the opportunity to ask questions and have had my questions answered satisfactorily, and that I am eligible to give this consent and agreement. I further confirm that I understand that I have the right to revoke this consent, or any part of it, at any time during my/the patient's treatment by HSS.

Signature of Patient/Parent/Guardian/Health Care Agent/Other Surrogate _____ _____ _____
Date *Time*

Relationship to Patient _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this General Consent/Permission for Treatment & Financial Agreement.

Signature of Witness _____ _____ _____
Date *Time*