

**GENERAL CONSENT FOR MEDICAL TREATMENT AND  
PERMISSION TO RELEASE INFORMATION FOR BILLING**

I understand that I have the right to make informed decisions about my health care treatment. I agree to have the doctors and staff do tests and treatments they feel are needed for my care. These may include x-rays, scans, lab tests, vital signs, medicines and physical therapy. I know other treatments or tests that have more risk will be explained to me so I can give informed consent for them if I need them. I know I can ask my doctor any questions I have about my treatment.

I know there are rules at the hospital. I understand that the doctors and staff will help know what the rules are. I agree to follow the rules for my safety and for the safety of others.

I know the hospital is not responsible for any of my belongings that I choose to keep with me. I agree that I should send any valuables and belongings I do not need home with my family or friends, or ask the staff to have the Department of Security hold the items.

I ask my insurance or other payor to make direct payment to this hospital and my doctors for all services that are covered by my benefits. I know that I have to pay any unpaid amount for my care that is not covered or is considered out of network by my insurance or other payor. If I do not pay my bills, I know they will be sent to collections. I agree I will pay any attorney fees, collection fees and court costs from this process.

**If I receive Medicare**, I agree that the information given by me to apply for payment is correct. I have been given a paper listing my rights as a Medicare patient. I know I have the right to ask for a review of my record to find out about any payments I may owe if Medicare will no longer cover my stay.

**If I receive Medicaid or Disability**, I agree to have a person from OSU Health System or a company working with them act on my behalf in dealing with the State Department of Human Services. They may request a hearing or seek information from my file as the need arises.

I agree to have information about my care and treatment released to:

- My doctors and other health care providers who provide care to me
- My insurance company and others who pay on my bills for care
- Companies that help collect payment for my care
- Any government agency to which I have applied for aid

If I have had treatment for alcohol or drug abuse, psychiatric issues, HIV or AIDS, that information may also be released.

I have read this and understand this form, or had this form read and explained to me. I sign this form as my consent.

\_\_\_\_\_  
**Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Agent**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Witness (optional)**



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**THE OHIO STATE UNIVERSITY MEDICAL CENTER**

**GENERAL CONSENT FOR MEDICAL  
CARE AND TREATMENT**

**Patient Name:**

**Medical Record Number:**

**Date of Birth:**