CHI Memorial
Imagine better health.℠

159804

Patient Identification

INDIVIDUAL DOCUMENT ACKNOWLEDGMENT OF PATIENT INFORMATION GUIDE

I,_____, acknowledge that I have received a copy of CHI Memorial's Patient Information Guide that includes:

- Patient Grievance Process Notice
- Notice of Patient's Rights
- Patient Safety

Individual (or personal representative of the individual) did not sign the acknowledgment for the following reason:

- ☐ Individual refused
- ☐ Individual refused, stating that he/she has already signed an acknowledgment
- ☐ Individual unable to sign because of medical condition
- ☐ There was not a personal representative of the individual available to sign
- ☐ Other

(explain):_____

_____

_____

Signatures:

_____	_____	_____
Signature or Initials of Individual	*Date*	Time
_____	_____	_____
Personal representative of individual if individual unable to sign	*Date*	Time
_____	_____	_____
Signature of Witness	*Date*	Time

CHI Memorial

Imagine better health.℠

In order to benefit from participating in Cardiopulmonary Rehabilitation it is imperative that you attend all scheduled appointments. Depending on your schedule, you will be expected to attend 3 days per week for 18-36 sessions based on your risk stratification. If you are unable to attend your scheduled session due to circumstances such as illness or Doctor's appointments, it is your responsibility to notify a staff member. Based on your insurance coverage, you may be expected to complete the program within a certain time frame. Therefore, it is important that all scheduled appointments are met. If you fail to attend three consecutive sessions without valid documentation such as notifying staff of illness, Doctor's appointments, etc. we will have to discontinue your treatment. In signing this form you have agreed to the above terms.

Signature _____ Date _____

Witness _____ Date _____

Cardiac Rehabilitation Important Numbers

Main Office 495-7764

Phase II 495-4140

CHI Memorial

Imagine better health.℠

Informed Consent for Exercise Treatment

In order to maintain my physical conditioning and exercise capacity and generally aid in my medical treatment for heart disease. I, _____, hereby consent to enroll and participate in the Cardiopulmonary Rehabilitation program at Memorial Hospital.

The program will follow an exercise prescription and Plan of Care prepared by clinically trained Cardiopulmonary Rehabilitation staff. The amount of exercise will be regulated on the basis of my tolerance. I understand that professionally trained clinical personnel will give me proper instructions and techniques for exercise and how to use the exercise equipment. I am aware of signs / symptoms and will inform a staff member if any occur. I will also inform staff of current medications and keep them informed of side effects and any changes in dosages, frequency, or types.

My program may also include weight-training activities with dumbbells or weight machines to improve my upper and lower body strength and muscular endurance. I understand that additional risks due to weight training may include injury due to dropping weights, muscle soreness, tendon or muscle strains, or joint irritation. I understand that I may also experience shortness of breath, elevated blood pressure, elevated heart rate, chest discomfort, or chest pain.

I have been informed and understand that there exists the possibility of injury or adverse changes during exercise which include, but are not limited to abnormal blood pressure, fainting, heart rhythm changes, and in rare instances heart attack, stroke, or death. Emergency equipment and trained personnel are available to deal with any situation that may arise.

I have been informed that the information, which is obtained in this program, will be treated as privileged and confidential information and will consequently not be released to any person, except my referring physician or the onsite supervising physician, without my express written consent. Only staff members, in the course of prescribing exercise, planning my program, or advising my referring physician or onsite supervising physician of my progress, will use information obtained.

I understand that hemodynamic information (i.e. heart rate, blood pressure, electrocardiogram, oxygen saturation) or anthropometric measures (i.e. weight, height) may be seen or heard by other patients in the Cardiopulmonary Rehab program during my scheduled class.

I have been given the opportunity to ask questions concerning the program plan and understand the risks associated with an exercise program. I am satisfied with the information given to me at this time and it is my desire to participate. I acknowledge that I have read this document in its entirety (or it has been read to me.)

I hereby consent to rendering of all services and procedures as explained by all Cardiopulmonary Rehab staff members of Memorial Hospital.

_____ _____

Signature of Participant Date

_____ _____

Signature of Witness Date

CHI Memorial

Imagine better health.℠

CONDITIONS OF ADMISSION AND GENERAL CONSENT FOR TREATMENT

8. **MEDICARE BENEFITS.** If the patient is covered by Medicare, the undersigned certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf. The undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit claim to Medicare for payment to the patient.

9. **WORKERS' COMPENSATION AUTHORIZATION.** If my admission to the hospital is a result of a work related injury, I hereby waive any privilege I may have with any physician, psychiatrist, chiropractor, hospital, or other healthcare provider, and I hereby authorize such healthcare provider to provide the worker's compensation administrator for this facility, any information, including, but not limited to, a right to inspect and copy all records, x-rays, x-ray reports, medical charts, or prescriptions, reasonably related to my injury or to my past relevant medical history. A copy of this form may be accepted in lieu of the original. In the event there is a dispute about the compensability of my claim for worker's compensation benefits, and if my employer is not specifically determined by a Court or the Department of Labor to be responsible for worker's compensation medical expenses for the condition or injury that is the basis of my admission, I agree to be personally responsible for all such expenses. I further agree that if my worker's compensation claim is settled with my employer on a disputed basis without a specific finding that such is compensable as a worker's compensation injury, I (or my attorney if I am represented), will withhold sufficient funds from any settlement to pay all amounts owed to the hospital for treatment of the condition which is the basis for this admission; and I hereby grant an assignment to the hospital for payment of all such expenses under such circumstances.

10. **PAYMENT GUARANTEE.** The undersigned agrees, whether he or she signs as a patient, as patient's guardian, as patient's agent, or representative, or as guarantor on behalf of patient, that in consideration of the services rendered to the patient, he or she and/or guarantor hereby individually obligate themselves to pay the account owed by the patient to the hospital. Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable attorney's fees and/or collection agency fees, and all other costs of collection, including court costs. The undersigned further authorizes the transfer of any overpayment on this account to be applied to any accounts on which the undersigned is a patient, guarantor, or otherwise legally responsible.

11. **COMMUNICATIONS CONSENT:** By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services.

I, the undersigned, declare and represent that I have read this document, understand it, and that any questions have been answered to my satisfaction. The undersigned further certifies that he/she is the patient or is duly authorized by the patient as the patient's general agent or representative to execute the foregoing and accept its terms.

_____ _____ _____
(Patient Signature) *(Date)* *(Time)*

_____
(Print Patient Name)

_____ _____ _____
(Agent, Representative, Spouse Signature) *(Date)* *(Time)*

_____ _____
(Print Patient's Agent, Representative, Spouse Name) *(Print Relationship to Patient)*

_____ _____ _____
(Witness Signature) *(Date/Time)* *(Guarantor)*

Memorial does not discriminate on the basis of race, color, national origin, sex, religion, age or handicap status in employment or the providing of services.