Georgetown University Hospital

CONSENT FOR TREATMENT, RELEASES, ACKNOWLEDGEMENTS AND FINANCIAL AGREEMENT FORM

Students, you must bring to Washington:
1. **This form (Consent for Treatment) - Completed & Signed**
2. **Medical Questionnare Form - Completed & Signed**
3. **Insurance Card (or copy of front and back)**

By my signature on this form, I agree that I:

1. General Consent for Treatment. Voluntarily consent to and authorize such care and treatments, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications ("Treatments"), by employees and authorized agents of Georgetown University Hospital("Hospital") as may be considered necessary or advisable in their professional judgment, and may include the drawing and testing for HIV (the virus that causes AIDS) and other blood borne diseases. I further acknowledge that no guarantees have been made regarding the effect such Treatments on any medical condition.

2. Right to Refuse Treatments. Understand that I have the right to make informed decisions regarding all care and Treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any Treatments that I do not want.

3. Assignment of Benefits / Financial Responsibility. Authorize and Assign all claims for and payments of any insurance benefits, workers' compensation benefits, government agency and disability benefits, directly to the Hospital for services rendered. I further assign the proceeds of any settlements, judgments or verdicts from third party liability claims for injuries treated by the Hospital to the Hospital in an amount equal to the outstanding balance of all charges due and owing. I agree that any excess payments may be applied by Hospital to satisfy any outstanding accounts resulting from prior admissions or treatments. As the patient, responsible party, or guarantor of payment for patient, I agree to be responsible for all charges not covered by the patient's insurance coverage or other claims. I further agree that in the event payment is not made in full for all Hospital charges, that to the extent permitted by applicable law, I shall pay all Hospital costs of collection including reasonable attorney's fees and/or collection agency fees.

4. Property Release. Release the Hospital from any responsibility for valuables, money, personal or other possessions which are not properly deposited by me with the Hospital depository and that in any event the Hospital's maximum liability shall be $500.00.

5. Acknowledgment of Receipt of Notice of Privacy Practices. Acknowledge that I have received or decline the MedStar Health Notice of Privacy Practices and acknowledge that this notice is available for me to keep.

For Georgetown University Hospital Use Only

Patient signature / acknowledgement of receipt of Notice of Privacy Practices not obtained because:

☐ **Emergency patient**

☐ **Patient / Patient Representative declined to acknowledge**

☐ **Patient / Patient Representative unable / unwilling to acknowledge receipt**

_____
GUH Representative

By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Representative to sign this document and be bound by its terms.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name of Parent/Guardian Relationship to Student

_____ _____ _____ _____
Address City State Zip

Georgetown University Hospital

MEDICAL QUESTIONNAIRE FORM

Students, you must bring to Washington:
1. **This form (Medical Questionnaire) - Completed & Signed**
2. **Consent for Treatment Form - Completed & Signed**
3. **Insurance Card (or copy of front and back)**

Last Name _____ First Name _____ DOB _____

Height ft _____ in. _____ Weight _____lbs. Date of last tetanus booster _____

Yes No

❑ ❑ Do you have difficulty with mobility and/or require assistance to walk such as a wheelchair, crutches, or cane? Describe _____

❑ ❑ Do you take any prescription or nonprescription medications regularly? Specify _____

Do you have or have you had in the past any of the following?

❑ ❑ A. Any orthopedic problems (acute or chronic sprains, casts)? Date Describe _____

❑ ❑ B. Cerebral palsy or other physically debilitating ailment such as MS, JRS, SLE, MD? Describe _____

❑ ❑ C. Any allergies severe enough to cause a reaction, such as hay fever or allergies to cigarette smoke, food, bee stings, or other insect bites? Any known drug allergies? Date of Reaction, Describe _____

❑ ❑ D. Professional help, evaluation, testing, or hospitalization for a physical or mental condition? Describe _____

❑ ❑ E. Any history of seizures, epilepsy, or convulsive disorder (controlled or not)? Describe _____

❑ ❑ F. Any gastrointestinal disorders such as nervous stomach, ulcer, or colitis? Describe _____

❑ ❑ G. Impaired hearing or deafness, significant loss of sight, or legal blindness? Describe _____

❑ ❑ H. Recent operations or significant operations in the past? Describe _____

❑ ❑ I. Asthma or any other problem of the respiratory or cardiac system? Describe _____

❑ ❑ J. Diabetes? Date Specify insulin type, dose, frequency, and testing method. Describe _____

❑ ❑ K. Are you pregnant? Due Date _____

❑ ❑ L. Any other chronic conditions ? Please be specific _____

I hereby certify that to the best of my knowledge the above information is complete and accurate.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Printed Name of Parent/Guardian Relationship to Student