Roy Lester Schneider Hospital
Myrah Keating Smith Community Health Center
Charlotte Kimelman Cancer Institute

Date: _ _ / _ _ / _ _ _ _ Time: _____ AM / PM

CONSENT FOR ADMISSION/REGISTRATION TO HOSPITAL, MEDICAL TREATMENT INCLUDING EMERGENCY TREATMENT, RELEASE OF RECORDS AND RESPONSIBILITY

Name: _____ Date of Birth _ _ / _ _ / _ _ _ _

1. I/We the undersigned, knowing that _____ is suffering from a condition requiring diagnosis and medical, surgical, emergency treatment or newborn care hereby voluntarily consent to such diagnostic procedures and facility care by or under the supervision of Dr. _____.
2. I/We are aware that the practice of medicine or surgery is not an exact science, and I/We acknowledge that no guarantees or assurances have been made to me/us with regard to the results that may be obtained from treatments or examinations at our facilities.
3. I/We acknowledge that SRMC does not assume responsibility for loss or damage to personal property kept in the patient's room. I/We further acknowledge that while the safe is available for the keeping of money and valuables of the patient, the Schneider Regional Medical Center assumes no responsibility for any possessions deposited therein.
4. I/We consent to allow students from formal education programs for health care professions to participate in my/the patient's care, under the supervision of appropriately licensed and/or credentialed members of such disciplines.
5. I/We acknowledge that I/We have received a written document regarding my/the patient's rights under Virgin Islands law to make decisions about my/the patient's medical care, and specifically about advanced directives, (i.e. living wills, etc.) NOTE: Included in this document is information about the Roy L Schneider Hospital's policies as regards advance directives.
6. If applicable, I/We authorize the Roy L Schneider Hospital's pathologist to use discretion in the disposal of any specimen or tissue obtained from the patient in the course of diagnosis or treatment.
7. If applicable, I/We consent to the administration of such anesthetics as are necessary and applied by or under the direction of the medical anesthesia department. Note exceptions if any _____.
8. I/We understand that some insurance companies require authorization for inpatient admissions or specific procedures, and that maximum reimbursement may not be received if authorization is required and I/We do not have it. I/We assume the responsibility of obtaining such authorization if necessary and understand that Schneider Regional Medical Center cannot obtain such authorization for me/us.
9. I/We authorize SRMC and/or any clinician involved with my/the patient's care including those performing x-ray services, anesthesia services, pathology services, emergency services, delivery and care of newborns, or other similar services to release any information from my/the patient's medical record as requested by the patient's insurance company for payment of the facility's or physician's accounts.
10. I/We assign all insurance benefits due to or received by me/us to Schneider Regional Medical Center, and/or the clinicians involved with my/the patient's care including those performing x-ray services, anesthesia services, pathology services, emergency services, delivery and care of newborns, or other similar services as total or partial payment for services provided. I/We understand that this assignment may not constitute full payment of my/the patient's bill and does not relieve me/us from liability for the unpaid balance. If insurance benefits to which I/the patients are entitled are paid directly to me/us, such benefits will be immediately delivered to SRMC (or the appropriate physician) by me/us until the full amount of all charges incurred are paid in full. I/We agree to pay directly to SRMC and/or such clinicians the charges incurred for services received, at their established rates. I/We will pay all attorney fees and court costs incurred by SRMC or such clinicians in collecting any unpaid balances for services I/the patient received.
11. I understand and consent to the use of digital communication methods, including automated messaging, email, text message, and secure patient portal, for the purpose of my care and claim follow-up requirements, and that these methods have privacy risks and protections explained to me. I further acknowledge that artificial intelligence (AI) tools may be used to support documentation, communication, or decision-making in my claim adjudication process. I have had the opportunity to ask questions, have received clear answers, and may opt out of digital or AI-assisted services at any time. My consent is documented and can be withdrawn upon written or verbal request

***Please sign the back of this page**

12. I consent to receiving calls, text messages and emails SRMC, its providers, or third-party business associates to any telephone number or email address provided by me. I understand that such calls or text messages may incur fees. I accept calls made using an automated dialer or prerecorded voice or artificial voice messages for the purpose of contacting me about my care, appointments, health benefit coverage, account information, billing and debt collect, or any other legal purpose. I understand that my consent is valid unless it is revoked by me.
13. I/We agree that the information provided here is true and accurate. I/We understand failure to provide accurate information may preclude ability to file insurance benefits thereby reverting to self-pay.

DO NOT SIGN THIS FORM UNTIL YOU READ IT AND UNDERSTAND ITS CONTENTS

_____

Patient Signature **Date**

_____

Witness (Print Name) **Witness (Signature)** **Date**

If Patient is unable to consent or is a minor, complete the following:

☐Patient is a minor _____ years of age ☐ Medical Condition ☐ Other: _____.

_____

Print Name of Guardian/Relative **Telephone Number(s)**

_____

Signature of Guardian/Relative **Date**

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