AGREEMENT FOR TREATMENT, EXAMINATION, AND ADMISSION

DEFINITIONS: All references in this consent form to "SCL Health" shall mean Sisters of Charity of Leavenworth Health System, Inc. and any and all of its controlled affiliates, including but not limited to its hospitals and clinics.

AGREEMENT FOR MEDICAL EXAMINATION – TREATMENT CONSENT, REPORTING REQUIREMENTS OF CERTAIN MEDICAL CONDITIONS AND INDEPENDENT CONTRACTOR STATUS OF SOME HEALTHCARE PROVIDERS.

This "Agreement for Medical Examination – Treatment Consent, Reporting Requirement for Certain Medical Conditions and Independent Contractor Status of Some Healthcare Providers" section gives SCL Health and affiliated Clinicians permission to perform medical treatments, procedures, examinations and tests on you as explained below:

- I understand that my care is under the supervision and control of my attending/treating physician(s) and/or health care providers such as Physician Assistants or Nurse Practitioners (collectively "Clinicians"), as allowed by law.
- I give permission for all medical treatments, procedures, examinations including X-Ray/medical imaging, administration of drugs, and/or any other diagnostic or therapeutic tests reasonably necessary for my proper care, including HIV testing. I understand that all of these procedures and/or tests may be done on an inpatient, observation or outpatient basis while I am in the hospital and on an outpatient basis after my discharge from the hospital or as a clinic patient without regard to any hospital status. My permission is given for continued procedures and tests on a recurring or on an as needed/as individually ordered basis. I understand that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures.
- I understand and agree that there may be circumstances under which the Clinician(s) or the hospital/health care facility is required to report to outside third parties such as health departments or the Center for Disease Control and Prevention (CDC) information pertaining to communicable diseases such as HIV, TB, and viral meningitis. I understand that disclosure of my Federal Social Security Number in reference to Medical Devices is required by the FDA under the Safe Medical Devices Act of 1990 and also for other state and federally mandated requests.
- I give permission that aspects of my care and treatment may be recorded and/or filmed for internal SCL Health purposes, such as medical/nursing student education or for quality purposes.
- I understand that no person has the authority to alter or amend this paragraph or any other paragraph in any manner.
- I give permission to the disposal by SCL Health of any tissues or parts which may be removed in the course of any procedure performed upon me. Body fluid exposures will be managed according to the laws of the state in which the SCL Health facility is located or by other applicable law.
- If I am pregnant I also give permission for testing and treatment of my unborn child and my newborn infant – all of this form applies equally to me, my unborn child, and my newborn infant.

I recognize and understand that all Clinicians furnishing services to me, including, but not limited to, my attending physicians, other physicians holding clinical privileges at this facility or clinic, and other physicians such as those providing services to me in anesthesiology, radiology, pathology and emergency medicine, may be independent contractors and are not the employees or agents of SCL HEALTH or of each other while providing professional services. I am signing this form with the understanding that SCL HEALTH and the Clinicians are providing services to me in express reliance on this written statement/my signature.

CERTIFICATION OF AGREEMENT TO BE BOUND BY THIS AGREEMENT

I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT OR SERVICES PROVIDED OR TO BE PROVIDED TO ME. I CERTIFY THAT I HAVE READ THE ABOVE AGREEMENT (OR IT HAS BEEN READ TO ME) AND I UNDERSTAND WHAT IT SAYS. MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE BEEN OFFERED A COPY OF THIS DOCUMENT. I CERTIFY THAT I AM THE PATIENT OR PERSON DULY AUTHORIZED BY THE PATIENT TO EXECUTE THIS AGREEMENT AND I AGREE TO ITS TERMS.

Date	Time	Signature of Patient (or Patient's Personal Representative and relationship to Patient)
Date	Time	Signature of Witness

SCL Health

ON025

Agreement For Treatment, Examination, and Admission

EH-FR-TX-0678-0517-SCLHS

PATIENT INFORMATION

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