



CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY AND HEALTHCARE OPERATIONS:

For the purposes of this consent, includes all hospitals, physician offices and other facilities providing healthcare services which are part of UMMS.

*Hereafter referred to as "PRACTICE"

REQUEST, AUTHORIZATION AND CONSENT FOR TREATMENT: I voluntarily request, authorize, and consent to care including medical and/or surgical treatment and diagnostic, radiology, and laboratory examinations and procedures by physicians, residents, nurses and other technical staff of PRACTICE. I understand and agree that healthcare professionals in training, which may include but are not limited to residents, fellows, medical/nursing/dental students may assist or participate in providing hospital and/or medical care to me. I understand that these professionals in training work under the direction or supervision of my physician or other healthcare professional and may perform or observe some of the health services I receive and specifically consent to.

I understand that the extent and severity of my injury or illness is not known at this time. I further understand and agree that the practice of medicine is not an exact science and that no guarantees have been made as to the results of either physician practice care and medical and/or surgical treatment or examinations. If applicable, I give PRACTICE permission to appropriately dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissues cannot be retrieved. I hereby authorize PRACTICE to retain, preserve and use for scientific or teaching purposes or dispose of at their convenience, any specimens or tissues taken from my body during any hospital/clinic procedure(s).

INDEPENDENT CONTRACTORS: I understand that some healthcare providers providing services to me may not be employees of PRACTICE. Some healthcare providers providing services to me may be independent contractors who have been granted the privilege of using the practice facilities to provide services for and on behalf of PRACTICE. I understand that if the employment status of a healthcare provider is important to me in making treatment and other healthcare decisions, I may inquire as to the employment status of the healthcare provider caring for me.

INSURANCE CERTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act and/or by any other third party payers is correct. I assign to PRACTICE all benefits for care due to me under the terms of said policies and programs but not to exceed the regular charges for similar services. I assign payment to the physician(s) rendering medical services and I assign payment for the unpaid charges of the physician(s) for whom the practice is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductibles, coinsurance, or any other expenses incurred which are not paid by any insurers or other third party payers.

MEDICARE AUTHORIZATION: I request payment of authorized Medicare benefits be made on my behalf for any service furnished me by PRACTICE, including physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

PHOTOGRAPHY and/or Video Record: The persons caring for you may need to photograph and/or record you to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or to help plan the details of surgery. Photographs and/or recordings taken for these clinical reasons do not require your written permission.1

PRIVACY OF INFORMATION: (Please check ☒ one)

 I **ACKNOWLEDGE** receipt of a copy of the Notice of Privacy Practices which explains how PRACTICE may use and disclose protected health information; or

 I **REFUSE** receipt of a copy of the Notice of Privacy Practices which explains how PRACTICE may use and disclose protected health information.

USE AND DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS: If I receive treatment for a substance use disorder at a program within PRACTICE, I consent to the program disclosing these records to others within PRACTICE and to other affiliates of University of Maryland Medical System that treat me for purposes of my treatment, quality improvement and other healthcare operations and care coordination. This consent will expire one year after I am no longer a patient of PRACTICE or other affiliates of University of Maryland. I may revoke this consent at any time except to the extent that the program, PRACTICE, or other University of Maryland Medical System affiliates have already acted in reliance on my consent.

GUARANTEE OF ACCOUNT: I acknowledge responsibility for this account and assume and guarantee payment of all hospital and physician charges, including copayments and deductibles and non-covered charges rendered to me during this visit. Should this account be referred to an attorney for collection, I agree to pay attorney fees, collection expenses, and interest at the highest rate authorized by law. I understand that I may be billed separately for services provided to me or on my behalf during this period of treatment by independent professional groups or hospital based physician services (radiology, pathology etc.).

WIRELESS COMMUNICATION: I expressly consent and authorize PRACTICE and its agents to:

- a. Contact me at any telephone number, including wireless numbers, email addresses, or unique electronic identifiers or modes that I provided to PRACTICE at any time associated with me or my account;
- b. Communicate with me using any current or future means of communication, including but not limited to, automated telephone dialing systems, artificial or pre-recorded messages, SMS text messages, or other forms of electronic messages; for any reason related to the services received at PRACTICE or services received at PRACTICE in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account; and
- c. Leave answering machine and voicemail messages, in compliance with applicable laws, for any reason related to the services provided by PRACTICE or services to be provided by PRACTICE in the future, including operations and quality matters, such as patient satisfaction surveys, and collection of amounts owed on my account.

I further promise to immediately notify PRACTICE if any telephone number, email address or other unique electronic identifiers or modes that I provided to PRACTICE change or are no longer used by me.

COVID-19: This practice is one of the places where patients have come to receive COVID-19 care. I understand that patient care and treatment decisions may be impacted as resources become affected due to our response to COVID-19. I understand that in an effort to limit unnecessary contact, providers may be augmenting their care with the use of telemedicine and other communication methods that the provider deems appropriate. I am aware that as with the use of any technology, the risk of equipment or security failures can exist despite best efforts. I further understand that although proper interventions are in place to minimize the risk of COVID-19 transmission, the ability to completely remove the risk is not possible. I understand this risk and consent to be treated at this facility.

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I CERTIFY THAT I HAVE READ THIS CONSENT AND AM THE PATIENT OR THE PARENT OR GUARDIAN OF THE PATIENT OR AM DULY AUTHORIZED AS PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. BY SIGNING BELOW, I REPRESENT THAT THE INFORMATION GIVEN BY ME IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT OR RESPONSIBLE PARTY NAME

RELATIONSHIP TO PATIENT

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UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON MEDICAL GROUP

Authorization to Disclose Health Information
(Excluding Medical Records/PHI)

Patient Name: _____ Date of Birth: _____ Date: _____

Authorization to Disclose Health Information

I, _____, grant permission for the following person(s) to obtain information regarding medical care, and speak with the provider, and/or staff regarding the patient listed above.

Name

Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient or Responsible Party Signature

Date

Patient / Responsible Party Name

Relationship to Patient

OFFICE USE ONLY	UNIVERSITY OF MARYLAND BALTIMORE WASHINGTON SPINE AND NEUROSURGERY CENTER		Policy Number: [] New [X] Revised July 2019 [X] Reviewed July 2019	
	Subject: Prescribing of Opioid Narcotic Pain Medication Policy Neurosurgery Department		Effective Date	May 2013
	Originator: Manager of Out Patient Surgical Practices		Next Review Date	July 2020
COO: _____		Date: _____	Page	1
			Supersedes	

Purpose:

Establish a policy for prescribing of all Opioid Narcotic pain medications in the office.

Responsibility:

It is the responsibility of all staff of the UCMG BW Spine and Neuroscience Center at BWMC to adhere to this policy.

Procedure:

A. Surgical Patients:

1. All Opioid Narcotic pain medications will be prescribed for up to **six weeks** following the patient's surgery.
2. After 6 weeks, all patients in need of additional Opioid Narcotic pain medications will be asked to see a pain management specialist to help control the pain and prescribe any future medications.
3. Please schedule an appointment with your pain management provider as soon as you have your surgery date for 6 weeks from the date of surgery.
4. Please allow 48 hours for all medication refills. **Refill requests made after 12pm on Fridays will not be filled until the following Monday.**

B. Pre-Operative Prescription Management:

1. All patients scheduled to have surgery, within 14 days of their appointment with the physician and/or nurse practitioner, may receive Opioid Narcotic pain medications for the 14 days prior to surgery. (If surgery is rescheduled by the patient for any reason, that patient will be asked to go to their PCP or Pain Management physician for any further prescriptions).
2. All patients scheduled to have surgery after 14 days of their appointment with the physician and/or nurse practitioner, will be referred back to their PCP or Pain Management Specialist for any Opioid Narcotic pain medications. (We will provide a prescription for Opioid Narcotic pain medications for these patients for up to two weeks pending their appointments with the PCP or pain management physician)

All patients who are seeing multiple physicians will be asked to honor the office policy of full disclosure of **any** pain medications currently being prescribed by any other physicians prior to receiving any additional pain medications from our office. Any patients who choose not to abide by this policy, and are found to be receiving multiples of the same types of pain medications from different physicians, will be terminated from the practice immediately.

C. Non-Surgical Prescription Management:

1. Opioid Narcotic Pain medications will not be dispensed for patients who are not scheduled for surgery.

****Exceptions to this policy will be made on a case to case basis by the Physician and/or Nurse Practitioner, or Physician Assistant only****

Signature _____

Date _____

Printed Name _____