

**BERKSHIRE MEDICAL CENTER**  
**MEDICAL CONSENT**

PATIENT NAME \_\_\_\_\_

(MAY USE PATIENT LABEL)

PATIENT NUMBER \_\_\_\_\_

**CONSENT TO HOSPITAL ADMISSION AND MEDICAL TREATMENT:**

1. I, (or the person acting on behalf of the patient listed above), suffering from a condition requiring hospital care, hereby consent to the rendering of such care, which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or others of the hospital's medical staff consider to be necessary.
2. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this hospital.
3. I understand that:
  - a. It is customary, absent emergency or extraordinary circumstances, that no procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician (or in some limited cases another health care professional) to the patient's satisfaction;
  - b. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course; and
  - c. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent.
4. I understand that many of the physicians on the staff of this hospital, including my attending physician(s), are not employees or agents of the hospital but, rather independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Further, I realize that among those who attend patients at this hospital are medical, nursing and other health care personnel in training who, unless requested otherwise by the patient, may be present during patient care as a part of their education.
5. This form has been fully explained to me, and I am satisfied that I understand its content and significance.

**STATEMENT OF RECEIPT:**

I have been informed that a copy of Patient Rights and Responsibilities, as per Massachusetts General Law, Chapter 111, Section 70E, will available to me upon my arrival to my assigned nursing unit.

For Medicare Recipients, I have received a copy of An Important Message to Medicare Patients, explaining my rights as a Medicare Beneficiary and an explanation of PRO Disclosure of Confidential Information and A Notice of Your Rights from the Advocacy Office of the Massachusetts Department of Public Health.

For Military Dependents, I have received a copy of the document titled Important Message From CHAMPUS/CHAMPVA.

For all Patients 18 yrs or older, I have received a copy of the Advance Directives Fact Sheet along with a sample Health Care Proxy, which I may complete if I so desire.

I have an Advance Directive in place at this time. Y N Agent \_\_\_\_\_

I have provided a copy for my Medical Record. Y N Phone \_\_\_\_\_

**PRIVACY PRACTICES:**

1. I would like my name withheld from the Hospital Directory. (I understand the hospital will not acknowledge my presence as a patient to anyone, including my family and friends, who call or come to the Information Desk.) Y N
2. I would like my name withheld from the Religion Listing. (I understand that my name will not appear on printed lists provided to clergy sorted by Religion or Place of Worship.) Y N

=====

WITNESS \_\_\_\_\_ SIGNED \_\_\_\_\_

DATE \_\_\_\_\_ TIME \_\_\_\_\_ am  
pm RELATIONSHIP \_\_\_\_\_

\_\_\_\_\_ Patient is unable to sign this form due to severity of illness or is a minor and no patient representative was available to receive documents. Delivered to Nursing Unit for completion.