WVUMedicine
WEIRTON MEDICAL CENTER
601 Colliers Way
Weirton, WV 26062

GENERAL PATIENT CONSENT

Health Care Affiliates / WVU Medicine

1. I understand that West Virginia United Health System, Inc., doing business as West Virginia University Health System (WVUHS), is an integrated health system comprised of various entities, including (but not necessarily limited to), hospitals, clinics, clinical practice plans, services and other affiliates.

2. I understand that there are also separate clinical practice plans - West Virginia University Medical Corporation, doing business as University Health Associates (UHA), and West Virginia University Dental Corporation (WVUDC) - which support faculty providers and academic missions, and perform clinical administrative operations connected with patient care provided by UHA and WVUDC providers and staff.

3. The entities collectively referenced in Sections 1 and 2 will be referred to in this General Patient Consent Form (Form) as "Health Care Affiliates" and may also be collectively referred to as "WVU Medicine."

Consent for Treatment / Care

4. I consent (on my behalf or on behalf of the Patient) to medical care, examinations, procedures and/or treatment by Weirton Medical Center, Health Care Affiliates, and their physicians, allied health professionals, residents, students and ancillary staff, which may be performed on an inpatient or outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures (which may include testing for communicable diseases such as Tuberculosis, Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Meningitis, Mumps, and Chicken Pox, if a physician or allied health professional orders such tests or if ordered by protocol), x-ray examinations, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services. I understand that the health care providers may provide consultations and/or recommendations for certain tests and treatment to be performed. However, I also understand that I am entitled to make decisions regarding the medical care rendered, that the tests and treatment are voluntary, and that I am able to decline tests and/or treatment as I deem appropriate.

Financial Arrangement

5. I authorize Weirton Medical Center, and other Health Care Affiliates to bill my (or the Patient's) insurance carrier and request that payments be made directly to Weirton Medical Center. I certify that the insurance information provided is true and accurate. I understand any service not covered by insurance is my (or the Patient's, if applicable) responsibility.

6. I assign Weirton Medical Center all rights to insurance payments or benefits to which I (or the Patient) may be entitled to for services rendered by Weirton Medical Center, and/or other Health Care Affiliates to act on my (or the Patient's) behalf and as my (or the Patient's) representative to request consideration (internal and/or external review process) by my insurance company or utilization review entity for coverage grievance or appeal processes. I authorize the release of medical records as requested by the insurance company for claim processing and adjudication.

7. I understand that if I (on my behalf or on behalf of the Patient) select to pay for certain services out-of-pocket and thereby exercise my right to limit disclosure of the information to my (or the Patient's) payer regarding those services, a separate financial agreement will be put into place regarding self-pay services.

8. Weirton Medical Center recognizes that there are patients who do not have the ability to pay for medical services. I understand that, if my (or the Patient's) income is at or below the federal poverty guidelines, I (or the Patient) may qualify for charity care. I understand that if I wish to apply for charity, I must complete a financial assistance application form and submit it along with all of the requested documentation to Reynolds Memorial Hospital. I understand that charity application forms are available upon request from Admissions, Financial Counseling, or Financial Services personnel. I understand that submission of the completed charity application form does not guarantee that charity will be awarded. I further understand that certain services are not covered under the financial assistance program and that I can obtain the exclusion list from Admissions, Financial Counseling, or Financial Services personnel.

9. I also agree that if the facility must initiate collection efforts to recover amounts owed by me (or the Patient), then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by the facility in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the facility that applicable rules or statutes permit the facility to recover.

10. I authorize (on my behalf or on behalf of the patient) WVU Medicine to apply any overpayment, co-payment, or credit balance to my other WVU Medicine active accounts, which could include accounts for WVUHS or other entities affiliated with WVU Medicine, and other active accounts for University Health Associates (UHA), which is a separate physician group providing services at WVU Medicine facilities. I understand that this amount may not be refunded to the original payment method but used to offset balances on other accounts as specified above. I understand that I am not required to enter into this agreement as a condition of purchasing property, goods, or services. This consent shall continue until revoked by me or my duly authorized representative in writing.

Healthcare Providers

11. I understand that some of the physicians (who may consist of faculty, non-faculty, fellows, or residents), advanced practice providers, and licensed practitioners and staff who provide examinations and treatment may be independent contractors and are not employees or agents of Weirton Medical Center.

12. I understand that I have the right to choose the physicians (who may consist of faculty, non-faculty, fellows, or residents) and advanced practice providers who provide care to me. I also understand, however, that care and/or treatment may be limited based upon my provider preferences.

13. I understand that some Hospitals within WVUHS are considered teaching facilities or have educational programs, and that students may examine, assess, or provide care to me (or the Patient) under the supervision of licensed health care professionals, but that no diagnosis or treatment decisions will be made by students. I hereby consent to such care.

14. I understand that medical care and treatment will not entail any experimental procedures without my knowledge and consent.

15. I understand that Weirton Medical Center does not assume responsibility for personal belongings in my possession, and I (on my behalf or on behalf of the Patient, if applicable) release Weirton Medical Center from all liability for the loss or theft of, or damage to, such belongings.

16. I agree that my (or the Patient's) last name and general symptoms may be posted on a patient tracking board to facilitate my (or the Patient's) care.

Notice of Privacy Practices and Patient Rights and Responsibilities Acknowledgement

17. I understand that Weirton Medical Center is part of an organized healthcare arrangement and that these providers may share my (or the Patient's, if applicable) health information for treatment, billing, and health care operations. I understand that these organized healthcare arrangement members have the right to change this notice at any time.

18. I acknowledge that I have been offered a copy of Weirton Medical Center's Notice of Privacy Practices that describes in detail how health information is used and shared, and I understand the Patient Rights and Responsibilities, which are available at https://wvumedicine.org/patient-resources/rights-and-privacy/privacy-practice/.

Consent for Use and Release of Information

19. I authorize Weirton Medical Center and Health Care Affiliates - including their treating and referring providers and other staff members - to release any information about me and my health (or Patient and Patient's health, if applicable), the health services provided to me (or Patient), or payment for the health services rendered that may be necessary: (1) for treatment (to health care providers or facilities that need the information for continued care); (2) for any purposes related to payment for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); or (3) for the health care operations of Weirton Medical Center, and other Health Care Affiliates (quality assessment, training programs, planning, and fundraising). For more detailed information about the way my information (or the Patient's, if applicable) may be used or released, I can read Weirton Medical Center's Notice of Privacy Practices.

Communications Disclosure and Consent

20. I do hereby expressly consent to and authorize Weirton Medical Center, their affiliates, subsidiaries, or any third party contractors acting on their behalf, to contact me via live, automated or prerecorded telephone call or text message, or emails as regards to any products or services, or any other communications, at any of the telephone numbers, including mobile or cellular numbers, or email addresses I have provided to them. I understand that I am not required to enter into this agreement as a condition of purchasing property, goods, or services. As stated in Paragraph 25, this consent shall continue for a period of one year unless revoked by me or my duly authorized representative in writing. I understand that these methods of communication are not guaranteed to be secure or encrypted by Weirton Medical Center or third party contractors acting on their behalf, and using this service is at my own risk.

Acknowledgement of Use of Artificial Intelligence

21. I understand that artificial intelligence (AI) and similar technologies may be used to support delivery of care and treatment as well as business operations. For example, AI technologies may assist with clinical notetaking (such as AI scribing), summarizing my record, drafting routine communications, supporting clinical decision-making, detecting abnormalities in imaging tests, enhancing safety or quality checks, reviewing call center recordings, and improving scheduling or billing processes.

22. I understand that AI technologies may be utilized to enhance and optimize imaging interpretation and healthcare follow up. These tools may support early detection of conditions and assist with timely interventions. AI technologies may assist with identification of healthcare needs, prompt review by additional medical specialties, and indicate recommendations for further follow up and/or referrals. Critical health information detected through use of AI Technologies will be communicated as appropriate to either me or my identified healthcare provider so that I can make informed decisions about follow up medical tests, procedures, or other consultations that may be recommended.

23. I understand that AI technologies do not replace my clinician's professional judgment. A licensed healthcare provider remains responsible for reviewing my health information, verifying documentation, and making all final decisions regarding my diagnosis and treatment.

Consent to Photographs, Video and Audio Recordings

24. I consent (on my behalf or on behalf of the Patient, if applicable) to photographs, video, digital or audio recordings, and/or images for clinical monitoring, for security purposes, and/or the facility's healthcare operations (e.g. quality improvement activities). I understand that recordings may not be a part of my legal medical record. I acknowledge that the recordings or photographs may be disclosed as required or permitted by law.

Other Acknowledgements

25. I understand that this consent shall be valid for one (1) year, and at the conclusion of the one (1) year, it will be requested that you complete a new general consent. However, you may revoke this general consent at any time.

26. I understand that the following are not permitted on Weirton Medical Center's premises: handguns, firearms, and/or weapons of any kind; illegal substances or drugs; and alcoholic beverages. I understand and agree that I (or the Patient or other visitors) may be subject to a search of my/their person and belongings if it is suspected that I/they possess such items on Weirton Medical Center's property and, if found, that such items will be confiscated and disposed of as appropriate.

27. I understand that Weirton Medical Center is tobacco-free and, therefore, I agree to refrain from tobacco products on Weirton Medical Center's premises.

28. I understand that I (or the Patient) have the right to have visitors accompany me (or the Patient) during medical care and/or treatment at Weirton Medical Center. However, I understand that Weirton Medical Center may need to place clinically necessary or reasonable restrictions or limitations on visitors to protect the health and safety of me (or the Patient) in addition to the health and safety of other patients. Weirton Medical Center will explain the reason for any restrictions or limitations if imposed.

I have been given the opportunity to read and ask questions about the information contained in this General Patient Consent Form and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction. By signing this General Patient Consent Form, I acknowledge that I understand the above statements and that I agree to the same.

Please Print Patient's Name	Date	Time
Signature of Patient, Legal Guardian, or Legal Representative	Date	Time

Relationship to Patient if Signed by Legal Guardian or Legal Representative

Signature of Witness	Date	Time