



MedStar Health

Georgetown University Hospital

3800 Reservoir Road
Washington, DC 20007-

(202) 444-2000

Patient: **YOSHIMOTO, AYAE**

MRN: GUH-000002380268

FIN: GUH-07731765769

DOB/Age/Sex: 10/26/1994 31 years

Date of Service: 5/27/2024

Attending Provider: Glasser,MD,Eric G.

Female

Patient Viewable Documents

Report Request ID:

825627582

Print Date/Time:

11/26/2025 06:07

This report is confidential medical information. The unauthorized disclosure of this information may subject you to civil and criminal penalties.

EST

www.medstarhealth.org

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MedStar Franklin Square Medical Center
 MedStar Georgetown University Hospital
 MedStar Good Samaritan Hospital
 MedStar Harbor Hospital
 MedStar National Rehabilitation Hospital
 MedStar Union Memorial Hospital
 MedStar Washington Hospital Center
 MedStar Montgomery Medical Center
 MedStar Southern Maryland Hospital Center
 MedStar St. Mary's Hospital
 MedStar Ambulatory Services
 MedStar Health Home Care
 MedStar Health Physical Therapy _____ location
 MedStar Medical Group _____ location
 MedStar Health Urgent Care _____ location

ENTITY GENERAL CONSENT FORM

Page 2 of 2

MS 102600 (approved 10/13/23)

YOSHIMOTO , AYAE



7731765769

10/26/1994



2380268

PATIENT LABEL

I have also received the following documents, and they have been explained to me.

- Patient Rights and Responsibilities
- Notice of Privacy Practices
- Notice of the Financial Assistance Policy

- I have an Advance Directive (Living Will)

*If a copy is not in your record, please bring a copy to your next visit.

- Do you want information about Advance Directives or appointing a Health Care Agent?

^{AY}
^{AY}
^{AY}

Initials

Yes* No

Yes No

I understand and agree to the contents of this form. If I have question on the above documents, I will speak to a member of my care team.

Signature of Patient or Patient Representative

Date/Time

Printed Name of Patient Representative (if applicable)

Personal Representative Relationship to Patient (if applicable)

*If patient unable to sign AND healthcare agent or surrogate not available, attempt telephone consent.

Receipt of Entity General Consent via Telephone

Name of Patient or Representative

Providing Telephone Consent: _____

Printed Name

Relationship to Patient: _____

Printed Relationship

Associate Obtaining Telephone Consent: _____

Printed Name

Date

*MedStar Healthcare Entity Associate Section:

Complete this section if patient representative or telephone consent obtained to indicate reason patient did not sign form.

Check only one:

- | | | |
|--|---|--|
| <input type="checkbox"/> Emergency Patient | <input type="checkbox"/> Direct Admit/Transfer | <input type="checkbox"/> Incapacitated |
| <input type="checkbox"/> Clinical team concern for capacity | <input type="checkbox"/> Physical impairment | |
| <input type="checkbox"/> No representative information available | <input type="checkbox"/> Other (please specify) _____ | |

Associate Initials: _____

This form needs to be signed for each ED visit, hospital/facility-based service, including inpatient admissions, urgent care visit, and ambulatory surgery; annually for all other visits.

YOSHIMOTO , AYAE

ACCT: 7731765769

DOB: 10/26/1994 A/S: 29F

MRN: 2380268

Reg Date/Time: 05/27/24 11:28

Att Md: UNASSIGNED, UNASSIGN



MedStar Health

- MedStar Franklin Square Medical Center
 MedStar Georgetown University Hospital
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Page 1 of 2

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PATIENT LABEL

What Is This Consent For?

- I understand that I am allowing my care team, including clinical providers of the MedStar healthcare entity indicated above, to examine, treat and otherwise care for me, including by a secure telehealth platform.
- I understand resident physicians, medical students, clinical observers, and/or other health professionals in-training may observe or participate in my care under proper supervision.
- I understand that I may always refuse any treatment, test, or procedure.
- I understand that I may always ask questions about my treatment or condition.
- I understand that clinical photography/recording may be included with my treatment.
- I understand and permit a blood sample to be drawn to test for any infection which could be passed on to my care team if the care team member is exposed to my blood or other bodily fluid.
- I understand that if I need a procedure or want to join a research study, I will have to complete another consent form that is for the procedure or study.
- I understand that not all clinical providers are employees, servants, or agents of the MedStar healthcare entity indicated above. Rather, some are independent clinical providers who have been granted the privilege of using a MedStar facility.
- I understand that the MedStar healthcare entity indicated above is not liable for the care and treatment of these independent clinical providers.
- I understand that if it is important to me to know whether my clinical provider is an employee of the MedStar healthcare entity indicated above, I may inquire about their status.
- I understand the MedStar healthcare entity is not responsible for loss of information due to technical failures during telehealth care.
- I consent to the MedStar healthcare entity indicated above to contact me by phone, cell phone, SMS/text message, mail and/or email on my account. I understand I have the right to opt out of receiving SMS/text messages.

About My Financial Responsibilities. I understand that I am financially responsible for my bill in the event my insurance does not pay in its entirety or I am uninsured. I will be appropriately charged even if I leave before my visit is complete.

- **"Assignments of Benefits."** I understand and authorize any insurance payments (whether Medicare, Medicaid, or any other company) to be made directly to the MedStar healthcare entity indicated above and applied to my bill.
- **Provider Charges.** I understand I may also receive separate bills from the provider(s) involved in my care, including those providing consultation during my visit, or from third parties performing services, including outside reference laboratories.
- **My Ability to Pay.** I understand that payment plans are available based on my financial needs.
- Financial Assistance is also available for those that qualify for free or reduced care.
- If my bill goes to collections, I understand that I may also be responsible for those fees if a judgment is obtained.

About My Personal Information. I understand that the MedStar healthcare entity indicated above may release my final diagnosis and other medical information for the purpose of continuing my treatment, determining any payment, or assisting healthcare operations.

About My Valuables. I understand that the MedStar healthcare entity indicated above is not responsible for any loss or damage to my property. I have been advised that if possible, I should leave all money and valuables at home or with a friend or family member.

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