Georgetown University Hospital
3800 Reservoir Road
Washington, DC 20007-

(202) 444-2000

Patient: **LEE, JONG HYUN HYUN HYUN**
MRN: GUH-000002380178
FIN: GUH-07731762576
DOB/Age/Sex: 6/1/1993 32 years Male

Date of Service: 5/24/2024
Attending Provider: Rahman,MD,Sabrina

Patient Viewable Documents

MedStar Health

- ❑ 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

LEE , JONG HYUN

7731762576

06/01/1993

2380178 PATIENT LABEL

ENTITY GENERAL CONSENT FORM

MS 102600 (approved 10/13/23)

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.

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.

* M S 1 0 2 6 0 0 *

LEE , JONG HYUN

ACCT: **7731762576** **DOB: 06/01/1993** **A/S: 30M**

MRN: **2380178** Reg DateTime: **05/24/24 16:17**

Att Md: **UNASSIGNED, UNASSIGN**

MedStar Health

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

- Patient Rights and Responsibilities — JHL Initials
- Notice of Privacy Practices — JHL Initials
- Notice of the Financial Assistance Policy — JHL Initials
- I have an Advance Directive (Living Will) — ❑ Yes* ☑ No
  *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? ❑ 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 — May 24, 2024 (4:19PM ET) 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:

- ❑ Emergency Patient
- ❑ Clinical team concern for capacity
- ❑ No representative information available
- ❑ Direct Admit/Transfer
- ❑ Physical impairment
- ❑ Other (please specify)_____
- ❑ Incapacitated

Associate Initials:_____

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