ALLIED CARE EXPERTS
ACE MEDICAL CENTER VALENZUELA
A member of ACE Group of Hospitals

CONSENT FOR ADMISSION

Name of Patient: ✓ Age: ✓ Sex: ✓
Civil Status: ✓ Hospital No.: ____ Bed No.: _____ Attending Physician: ✓ Room No.: _____

CONSENT TO:

A. TREATMENT: The undersigned grants authority to Allied Care Experts Medical Center - Valenzuela and its staff to perform procedures and treatments necessary for its patient as may be determined by the professional judgment of the Attending Physician.

B. PROCUREMENT OF INFORMATION: The undersigned designates and authorizes Allied Care Experts Medical Center - Valenzuela to be his agent for the purpose of rendering such consent to other physicians, hospitals or clinics as may be necessary to obtain from them such previous or current records as are needed in the patient's medical care while in the Allied Care Experts Medical Center - Valenzuela.

C. RELEASE OF INFORMATION: Authorization is hereby granted to Allied Care Experts Medical Center - Valenzuela and its staff to disclose all or any part of the patient's record to:

1) Any person, corporation or agency which is legally responsible for all or any part of hospital's charges including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare fund or patient's employer;

2) The patient's personal physician or other physicians rendering professional care to the patient.

D. CONSENT TO DRUG POLICY: The undersigned agrees that any and all of drug/medicines required by and/or to be administered to the patient shall be secured, purchased and dispensed only from the hospital pharmacy.

WAIVER OF RESPONSIBILITY FOR ARTICLES OF VALUE: The patient agrees that:

1) Allied Care Experts Medical Center - Valenzuela is not responsible for the loss of any cash and/or articles of value which the patient has not declared and surrendered to the Hospital cashier for safekeeping; and
2) If, in spite of the exercise of due care and diligence, the article of value deposited was lost or perished through natural causes, the personnel of the hospital itself will not be held liable.

CERTIFICATION: The undersigned certifies that he/she has read the foregoing and/or the foregoing has been explained to him/her in a language/dialect that he/she understands the nature and purpose of these authorizations to his/her full satisfaction and that he/she is the patient or is duly authorized by the patient as his/her general agent to execute the above and accept its terms.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when patient is physically or mentally incompetent.

Patient is unable to sign because:
- ❑ He is a minor, _____ years of age ❑ He is physically or mentally incompetent
- ❑ Others: _____

IN WITNESS WHEREOF, I have hereunto set my hands this ____ day of _____, 20__ at Valenzuela City, Philippines.

Signed:

✓_____
PATIENT/RELATIVE
Signature Over Printed Name/Date
Relation to Patient: _____

Interpreted by:

_____
ADMITTING STAFF
Signature Over Printed Name/Date