BHU Consents

UnityPoint Health
Des Moines

I voluntarily request and give my consent for my admission to the Iowa Lutheran Hospital Behavioral Health Units. I understand that the treatment provided to me may include medical, behavioral, chemical dependency, and/or psychiatric treatment. I understand that the inpatient behavioral health units are closed and secured units and I agree to the conditions of treatment described below and consent to the procedures and services which may be provided as part of the treatment recommended by the attending physician(s) or other physicians on the Medical Staff of the Hospital.

I understand that the inpatient Behavioral Health Units at Iowa Lutheran Hospital are closed units and that the doors and exits are secured and locked at all times. If I should decide that I want to be discharged from the unit any time following admission, I understand that I may not be allowed to leave immediately and may be detained until my physician can be notified and makes the decision as to whether or not I can be discharged. If the physician believes that I may be a danger to myself or others, the physician may have me detained until a court can more adequately assess my condition and order my discharge or arrange for alternate care.

I understand that the practice of medicine, including psychiatry, is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examination or treatment at the Hospital.

I authorize Iowa Lutheran Hospital and my physician(s) to use my records and discuss aspects of my hospitalization for scientific or teaching purposes providing that my identity is not disclosed. I further authorize the Hospital to release health information related to this hospitalization to my health insurance company, health payor or third-party payor, or its authorized agents or representatives for the purpose of determining benefits payable in connection with the services provided by the Hospital. I also understand that information regarding my care and treatment may be discussed with any of my care providers who provide direct care and treatment to me, on a need to know basis, for the benefit of my treatment. Any information released to anyone else related to my hospitalization shall be subject to separate authorization and separately signed by my legally authorized representative or me.

I understand that the Hospital may take certain actions to protect me, other patients, or other persons in the Hospital against possible harm. One action may be to screen or search for such things as alcohol, medication, illegal drugs or dangerous instruments. I authorize the Hospital to take such actions, including room and strip searches when they have reason to believe that I may have such items or instruments on my person or in my possession. I further authorize that the Hospital, at the time of my admission, or upon my return to the hospital from a medical leave, may remove from me, send home, and/or store items in my possession, including medication, contraband, or any dangerous instruments.

PATIENT LABEL

ILH Consent to Admission to Child, Adolescent or Adult Behavioral Health Unit

I understand that patient valuables and personal belongings cannot be adequately secured in patient rooms and that personal property should remain at home or be sent home. Any medications brought to the hospital at the time of admission should be sent home also. I acknowledge that the Hospital shall not be responsible for my personal property, which is kept in my room, or on my possession. I have been told that valuables and personal property may be placed in safekeeping and a receipt of such property placed in the Hospital safe. I release the Hospital from all liability in connection with the loss or theft of my personal property which is not sent home or delivered to the Hospital for safekeeping and for which a receipt is not provided.

I further understand, that as a condition of admission to the Behavioral Health Units, that restrictions on my mail, email, messaging, video communications, and phone calls may be imposed, including monitoring, if such restrictions, in the judgment of my physician(s) are deemed necessary for safety purposes or therapeutic for my treatment.

By signing this form, I acknowledge that I have read and understand the statement and conditions of admission to the Behavioral Health Units and I agree to them. Any questions I have asked have been answered to my satisfaction.

In the case of a minor, the minor's parent, guardian, or custodian acknowledges that they have read and understand the statement and conditions of admission to the Behavioral Health Units and agree to them on the minor's behalf.

I understand that the Adult Behavioral Health Unit is a non-smoking facility. Nicotine replacement therapy will be available if indicated by my physician along with other supportive techniques.

***Patient's signature:** _____ **Date:** _____

Parent/Guardian Signature:_____

Relationship to Patient:_____ **Phone Number:** _____

***If patient lacks the legal capacity, please provide signature of person with legal authority to consent on behalf of the patient. If so, please indicate relationship to patient.**

Witness Signature: _____

PATIENT LABEL