A. CONSENT TO TREATMENT: I, _____ hereby authorize my physician and whomever he/she may designate as his/her assistant or consultant to render medical treatment to me. I consent to any hospital care which encompasses laboratory, diagnostic or medical treatment which my physician or his/her assistant or consultant may deem necessary during my hospitalization.

B. RELEASE OF INFORMATION: I hereby authorize West Jefferson Medical Center to obtain my medical information from other health care providers and suppliers (i.e.: hospitals, physicians, pharmacies, etc...) as needed for my care and treatment and to provide my medical information compiled during this admission for review (and/or copy) as requested by my insurance company or a designated agent, or any liable third parties (to include Medicare and Medicaid) whose benefits have been assigned for purposes of utilization review for admission and/or continued stay, for benefit payment and for physician billing. I further authorize my treating physicians to request my medical records from any and/or direct copies of my medical records to other physicians, hospitals, pharmacies and other health care facilities as they deem necessary for continuity of care. State and Federal regulations may require West Jefferson Medical Center to report information about patients.

C. PATIENT'S PERSONAL PROPERTY: West Jefferson Medical Center is not responsible or liable for any patient or visitor personal property. This includes but not limited to items such as **EYEGLASSES, DENTURES, HEARING-AIDS, CLOTHING, etc., and VALUABLES such as MONEY or JEWELRY.** Valuables may be deposited in the Hospital safe at any time. Valuables may also be retrieved at any time.

D. ASSIGNMENT OF BENEFITS: I hereby assign and authorize payment directly to West Jefferson Medical Center of any hospital benefits, sick benefits, or injury benefits due because of liability of a third party, proceeds of all claims resulting from the liability of a third party, payable by any party, organization, etc., to or for the patient unless the account for this hospital, outpatient treatment or series of outpatient treatments is paid in full upon discharge or completion of outpatient treatments. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until this account for hospitalization is paid in full. I understand that I am responsible for any hospital charges not covered and hereby appoint West Jefferson Medical Center as my true lawful attorney to act on my behalf to collect the above mentioned claims and to give full and final receipt to me for all amounts so collected, and to endorse for me any checks made payable to me for benefits or claims collected on the above agreement. The undersigned agrees that any overpayments collected on the above admission or outpatient treatments may be applied directly to a delinquent account of the patient or any delinquent account for which the patient or guarantor is legally responsible at the time of collection or the overpayment.

E. ASSIGNMENT OF PHYSICIAN BENEFITS: I hereby authorize and assign payment to the physicians (Radiologist, Pathologist, Anesthesiologist, Emergency Room Physician, attending physicians and all other consulting physicians that may be deemed necessary) all insurance benefits and proceeds of any claims which I may have against any third party in connection with any event resulting in my need for medical services. This assignment also applies to only the Medicare claims for which assignment is accepted by the physician.

F. MEDICARE PATIENTS CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of authorized benefits be made on my behalf. I certify that the information supplied below is also correct. I also understand any non-covered item or services that I receive are my responsibility, and I will be billed accordingly. Those non-covered items and services include routine physical check-ups, eyeglasses, contact lenses, eye examinations, hearing aids, immunizations, orthopedic shoes, custodial care, cosmetic care, cosmetic surgery, dental services, person comfort items, routine foot care, private room difference, or any item or service not reasonable and necessary for the diagnosis or treatment of an illness or injury.

G. PAYMENT GUARANTEE: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, the undersigned individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Furthermore, the undersigned is obligated to make weekly or monthly payments if requested. Should the account be turned over to a collection agency or an attorney for collection, the undersigned shall pay all collection fees and reasonable attorney's fees. All delinquent accounts may bear interest at legal rates.

H. GENERAL DUTY NURSING: The hospital provides general duty nursing care. Under this system nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by the patient, or his legal representative, or his physicians, and the hospital shall in no way be responsible for the failure to provide the same and is hereby released from any and all liability from the fact that said patient is not provided with such additional care.

I. ACKNOWLEDGEMENT FOR THE RECEIPT OF DOCUMENTS: I hereby acknowledge the receipt of the documents indicated with an "X" below:

_____ Medicare Important Message _____ Champus Important Message _____ Advance Directives _____ Patient Rights
_____ Medical Necessity Review Organization _____ Privacy Notice _____ Balance Billing Notification _____ GNOHIE Opt Out

- **The undersigned certifies that he/she has read all of this document and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above agreements and accepts and understands its terms.**
- **I CERTIFY THAT I HAVE READ (OR HAD READ TO ME) AND FULLY UNDERSTAND THE ABOVE.**

Signature of Patient: _____ Date _____ Time _____

Printed Name: _____

Interpreter: _____Interpreter Code: _____

Signature of Authorized Person if Patient is a minor
Or otherwise unable to sign _____ Relationship to patient _____

Reason patient is unable to sign _____
Witness _____ Date _____ Time _____

Verbal Telephoned
Consent or Wire by _____ Date _____ Time _____

Witness _____ Date _____ Time _____

Witness _____ Date _____ Time _____

CONDITIONS OF TREATMENT AND/OR SERVICES

West Jefferson Medical Center