PATIENT NAME:_______________________________ **PATIENT NUMBER:** ___________________

______ **1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES**

The patient identified above consents to the procedures that may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, radiology examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered for the patient under the general and special instructions of the patient's provider. The patient also consents to the use of photographs and other imaging for treatment and Quality Assurance purposes, and understands that such images are considered a part of the either patient medical record or Quality Assurance records.

______**2. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND HEALTHCARE PROVIDER**

Some of the Healthcare Providers furnishing services to the patient are independent contractors with the patient and are not employees or agents of CCPHD#1. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such provider. The patient's provider has the responsibility to obtain the patient's informed consent, when required, to medical treatment or special diagnostic or therapeutic procedures.

_____**3. CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the Director of Compliance Programming, CCPHD#1. I hereby acknowledge that I have received a copy of the Notice of Privacy Practice for this facility and understand that I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

______**4. FINANCIAL OBLIGATIONS**

The undersigned agrees that, in return for the services to be rendered for the patient, the undersigned hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. However, if the patient is eligible to receive benefits under a health care service plan with which this hospital has contracted, the patient shall not be obligated to pay for services covered under the plan which is paid for pursuant to the contract. If any excess patient funds remain after payment in full of the charges for services rendered for this hospital visit, the undersigned hereby authorizes the hospital to apply such excess funds toward any non-covered services and/or other outstanding account(s) which the patient may have with hospital for any prior services rendered and for which the undersigned is responsible. Should the patient's account become delinquent and be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney s fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law. Payment is due at the time services are rendered. In certain circumstances, payment arrangements may be made in advance with our Business Office. We accept cash, checks, MasterCard or VISA. Returned checks are subject to a $25.00 charge in addition to what your bank charges you.

______**5. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL**

The undersigned assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to CCPHD#1 of all insurance (Medicare, Medicaid, Group, Indemnity, Work Comp and Motor Vehicle Accident) benefits otherwise payable to or on behalf of the patient for this hospitalization or for outpatient services, including emergency services if rendered, at a rate not to exceed CCPHD#1s regular charges. The undersigned, whether he/she signs as agent or as patient, assigns to CCPHD#1 any and all rights he/she may have against a health insurance plan relating to services provided at CCPHD#1, whether based on express or implied contract or upon statute,

including but not limited to any rights authorizing the collection of damages or penalties related to the insurance company s failure to timely or expeditiously pay a claim. It is agreed that payment to the hospital pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

______**6. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HEALTHCARE PROVIDER**

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any Healthcare Provider of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization or for outpatient services, including emergency services if rendered, at a rate not to exceed such Healthcare Provider s regular charges. It is agreed that payment to such Healthcare Provider pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

______**7. MEDICARE PATIENT'S RELEASE OF INFORMATION**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize CCPHD#1, any governmental agency, and any agent of any of the foregoing to release any information needed to act on this request or to verify my Medicare eligibility. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the Healthcare Provider(s) for whom CCPHD#1 is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by other insurance.

______**8. PHYSICIAN AVAILABLE NOTICE**

This facility does not provide on-site availability of a physician 24-hours per day, 7 days per week. Competent, fully-trained staff is available 24-hours per day, 7 days per week. Any patient who develops an emergency medical condition at a time when there is no physician present will be assessed and treated by qualified medical personnel, with physician support available via telephone, and/or called in as necessary, with transfer to another higher level of care institution when necessary.

9. HEALTH MAINTENANCE ORGANIZATION (HMO) ACKNOWLEDGEMENT

I have informed the hospital if I am currently a Member of an HMO, Medicare or otherwise. I may become an HMO member, either Medicare or otherwise, during this hospital stay.

	Yes	No		Yes	No
I have informed the hospital if I am Currently a Member of an HMO, Medicare or otherwise.			I may become an HMO member, either Medicare or otherwise, during this hospital stay.		

10. ACKNOWLEDGEMENT OF YOUR HOSPITAL STAY

Federal HIPAA Laws require that we obtain and understand what information we may release about you while you are in our care.

	Yes	No		Yes	No
Are we allowed to acknowledge your presence in our hospital?			Are we allowed to release your location in our hospital?		
Are we allowed to forward phone calls directly to you?			Are we allowed to release information regarding your condition?		
Are we allowed to release your name to members of the clergy?			Would you like to authorize us to be able to speak to your spouse or a family member about your medical information? If so, please provide name of person in blank below.		
Name:			Relationship:		

SIGNATURES

I certify that I have read the foregoing, received a copy thereof, have been given an opportunity to ask questions and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

______________________________ ______________________________

Date Patient/Parent/Guardian/Conservator

If other than patient, indicate relationship: ______________________________

Reason patient is unable to sign: ______________________________

Witness 1: __________________________ Witness 2: __________________________