CONSENT FOR SERVICES - The undersigned consents for Infirmary Health, its authorized representatives, and the patient's physicians to provide appropriate medical services including diagnostic and radiologic procedures , administration of medicines and other treatment and hospital care considered advisable or necessary by the patient's treating physicians . Physicians and their allied health professionals, including radiologists, pathologists, ER physicians and anesthesiologists, are independent contractors with the patient and are not employees or agents of the hospital. Any proposed surgery has been discussed with my surgeon and I have been informed about the procedure. Administration and maintenance of anesthesia may be appropriate and shall be supervised by an anesthesiologist and his representatives. Tissues and specimens shall be disposed of according to hospital procedures. unless otherwise directed by the patient. Absent emergency or extraordinary circumstances, no medical or surgical procedures will be performed upon a patient unless the patient has had the opportunity to confer with a physician or other health professional. The patient has the right to consent or to refuse consent to any proposed procedure or plan of treatment.

LIVING WILL/ADVANCE DIRECTIVE -
I received the brochure "It's Your Choice"_____
I have executed a Living Will or Advance Directive._____
I brought or validated a registry copy of my Living Will/Advance Directive and request it become part of my medical record._____
I understand that while I am an outpatient, my Advance Directive will not be honored._____

PERSONAL PROPERTY AND VALUABLES - Personal property and valuables should be given to family members or to Protective Services or other authorized hospital personnel for storage. I understand that the hospital is not responsible for any personal property or valuables, such as money, credit cards, jewelry, luggage, clothing, dentures, eyeglasses, hearing aids, or other prosthetic devices that are not stored by Protective Services or other authorized hospital personnel.
I do_____(do not),_____request storage of personal property and/or valuables.

FINANCIAL ASSISTANCE - The hospital has a Financial Assistance Policy/Program (FAP) for those patients who can't pay their Financial Obligation. If you can't pay your Financial Obligation, you should contact Patient Business Services at (251) 435-3541 to obtain a "Financial Assistance Policy- Plain Language Summary" and a "Financial Assistance Application Form". These forms may also be obtained from any registration area, or downloaded from our website:

https://www.infirmaryhealth.org/financial-assistance

IF YOU APPLY AND ARE ELIGIBLE for Financial Assistance, your Financial Obligation may be discounted in whole or in part. The hospital will advise you in writing of such eligibility, if any, and any remaining Financial Obligation. If you are not eligible under the FAP and cannot pay your Financial Obligation in full, please contact our Patient Business Services department at (251) 435-3541 to make payment arrangements; we have certain discount and payment programs which may be applied to your bill.

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FINANCIAL OBLIGATION - The undersigned, in consideration of the services to be provided, jointly and severally, agrees to pay all charges for such services, including without limitation any deductibles and/or co-insurance amounts, and any other charges not covered or allowed by health insurance payers (and if applicable, any amounts not covered or allowed by Home Health Agencies, where patient is under a current episode of care). Hospital charges will be according to Hospital's Charge-master. Physician charges will be according to their usual and customary rates. The undersigned agree to pay the Financial Obligation according to the hospital's or physician's credit terms, and agree that any payments made by or on behalf of the patient may be applied to any open account(s) the patient may have with the hospital, physician and/or their affiliated entities. If the undersigned fails to pay the Financial Obligation according to the hospital's or physician's credit terms and if the hospital or physician(s) files suit or takes other steps to collect any unpaid amount due, the undersigned agrees to pay the reasonable costs of collection activities, which costs may include a collection agency fee and/or a reasonable attorney's fee. Collection activities may include civil legal action, wage garnishment and/or reporting to consumer credit reporting agencies. The undersigned agrees and consents that the undersigned may be contacted regarding the Financial Obligation by telephone at any telephone number associated with his account(s), including wireless telephone numbers. The undersigned consents to be contacted by text messages, e-mails (using any email address associated with his account(s)), pre-recorded/artificial voice messages, and/or automatic dialing devices. If the undersigned is a family member or other representative of the patient, the undersigned is agreeing to all of the terms of this document on behalf of the patient and also guarantees payment of the Financial Obligation.

ASSIGNMENT OF BENEFITS - The undersigned assigns payment of authorized insurance benefits otherwise payable to the policyholder or beneficiary, including without limitation Medicare, Medicaid, and TRICARE, directly to the hospital, or its authorized representatives. The undersigned further assigns to the physician(s) who provide services or his authorized representative(s) such benefits payable for physician's services.

MEDICARE/ MEDICAID / TRICARE - Applies:_____
I certify that all information is correct which has been given to apply for payment under the Medicare, Medicaid, or TRICARE programs or other third party payers.
_____

AUTHORIZATION FOR RELEASE OF INFORMATION -
The undersigned authorizes the hospital and the treating physicians to furnish any medical and billing information about this account, including but not limited to the following:

(a) INSURANCE BILLING - information requested by the insurance company. Medicare, Medicaid, TRICARE or other third party payers to support the claim submitted for payment of charges applicable to this account.
(b) MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES - information requested by any utilization and/or peer review organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of this account or to determine benefits for related services.
This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. That revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized. Additional information may be released to medical device manufacturers for tracking purposes. The hospital may also disclose information which is appropriate for medical research screening to the hospital's Division of Clinical Research, who shall notify the patient's physician if the screening suggests potential benefit to the patient.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSES AND CONTENT.

_____
Signature of Patient or Patient's Representative — Relationship to Patient

_____
Signature of Policyholder, if different from Patient — Relationship to Patient

_____ _____
Date and Time: — Witness

PW Rev: 6/26/13

Room#:

Admit:

DOB:

AUTHORIZATION CONSENT