CONDITIONS OF SERVICES AT T. J. SAMSON HOSPITAL

Patient ID Label

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES

The undersigned consents to the procedures which 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, x-ray examination, medical and surgical treatment or procedures, anesthesia, or other hospital services rendered for the patient under the general and special instructions of the patient's physician or surgeon.

2. CONSENT FOR HIV/HEPATITIS TESTING

To protect against possible transmission of blood-borne diseases such as Hepatitis B, C, or Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood while I am a patient in the hospital. If any participants in my care are exposed to my blood, I understand that my blood, as well as the employee's blood will be tested. I further understand that my blood will not be routinely tested for these diseases unless ordered by my physician and that the results of any testing will be kept confidential.

3. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

All physicians and surgeons furnishing services to the patient, including the radiologists, pathologist, anesthesiologists, emergency room physician, and the like are independent contractors with the patient and are not employees or agents of the hospital. 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 the physician. I understand that there will be a separate charge for professional services, such as physician services. I understand that the hospital does bill for some professional services; otherwise, the professional fees are not included in the hospital's bill.

4. RELEASE OF INFORMATION

I hereby authorize T. J. Samson Community Hospital to release to any person or corporation, including but not limited to my insurance company, any physician, hospital, nursing home, home health agency, and/or worker's compensation carrier, who in its reasonable judgment has a legitimate interest, any information involving my care during my stay and after transfer or discharge from the hospital, including personal information such as my home, cellular and work phone numbers and address and email address. I also acknowledge that my medical records will be made available to governmental agencies as required by law. I further acknowledge that my medical records will be utilized in the hospital's utilization review, performance improvement, peer review and other similar processes and studies.

5. HEALTH INFORMATION EXCHANGE NOTIFICATION

Health Information Exchange (HIE) is a way for health care providers, hospitals, laboratories, and organizations involved in your care coordination and payment to see your electronic health records remotely via a secure network to provide you with the appropriate medical treatment and related services. I hereby authorize the Hospital to share my health information via a secure network, which includes electronic release of some or all of my health information. I understand this will remain in effect from the date of my signature below and applies to information in existence as of this date and any additional health information that may come into existence. The health care organization(s) and HIEs will use this information for the purpose of continuity of your care and will maintain the information according to its own policies and practices. It may re-disclose some or all of that information as permitted by state and federal laws and regulations.

6. MEDICARE PATIENT CERTIFICATION AND NOTICE

I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request that payment of authorized benefits be made in my behalf. I authorize the release of any information needed to act on this request. I understand that I am financially responsible for any remaining balance not covered by Title XVIII or XIX. I understand that I am responsible to pay for all items not covered by Medicare such as patient deductible, carry-home or personal items, walkers, and crutches, and drugs that can be self-administered but are not provided in the Emergency Room or Outpatient setting.

7. PERSONAL VALUABLES

I understand that the Hospital maintains a safe for the safekeeping of money and valuables, and the Hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The maximum liability of the hospital for loss of any personal property, which is deposited with the hospital for safekeeping, is limited to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

8. FINANCIAL OBLIGATIONS

The undersigned agrees, whether he/she signs as agent or as patient, that in return for the services to be rendered for the patient, the undersigned hereby individually obligates himself 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 healthcare service plan with which this hospital has contracted, the patients shall not be obligated to pay for services covered under the plan which are paid pursuant to the contract. If any excess funds remain after payment in full of the charges for the services rendered for this hospital visit, the undersigned hereby authorizes the hospital to apply such excess funds toward any other account(s) which the patient may have with the 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 shall bear interest at the legal rate.

9. ASSIGNMENT OF INSURANCE OR HEALTH BENEFIT TO THE HOSPITAL/PHYSICIANS

The undersigned irrevocably assigns, whether he/she signs as agent or as patient, direct payment to the hospital and physician(s) accepting this assignment all hospitalization and medical benefits applicable and otherwise payable to me for these services rendered by said hospital, physician(s), and other clinical providers. It is understood that he/she is financially responsible for charges incurred that are not covered under this assignment.

10. CONSENT FOR ELECTRONIC COMMUNICATION

I authorize the hospital and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and any third party agent of the hospital to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication. (I understand that standard text messaging rates may apply as provided by my wireless plan, and to contact my carrier for pricing plans and details). I authorize that at any time I provide an email or text address, this address may be used for electronic communication purposes to obtain feedback on my experience with the hospital's healthcare team.

11. CONSENT FOR PATIENT ASSISTANCE PROGRAM

I understand that the Hospital participates in programs to provide drug and device recovery services sponsored by drug manufacturers to eligible patients. By signing below, I authorize the Hospital, its agents and representatives, to use and disclose my protected health information ("PHI") and financial information in accordance with the terms and conditions of this Authorization. I understand that the Hospital or its agents may use and disclose my PHI for the purpose of contacting drug manufacturer sponsors, processing applications, managing claims, and participating in audits related to patient assistant programs. I authorize Hospital or its agents to complete drug manufacturers' application forms and to sign on the patient's behalf. The Hospital may not condition my treatment, payment, enrollment or eligibility for benefits on whether I choose to sign this authorization. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient of the information and thus, will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

12. PATIENT SELF-DETERMINATION ACT

I acknowledge that I have received a pamphlet, which describes patient's rights under state law to make decisions regarding my medical care. I hereby certify that a living will, healthcare surrogate, or durable power of attorney which authorizes one or more individuals to make decisions on my behalf has ____ has not_____been executed by me. I understand Advance Directives will not be honored in the outpatient setting. Initial _____

I ACKNOWLEDGE RECEIPT OF T.J. SAMSON'S NOTICE OF PRIVACY PRACTICES. Initial _____

I acknowledge that I have read the foregoing authorizations and assignments, that I understand, have legal authorization for, and agree to said terms and conditions in connection with the treatment of the patient. I permit a copy of this authorization and assignment to be used in place of the original for all purposes outlined herein. I reserve the right to withdraw this authorization at any time in writing. This, form has been fully explained to me, and I am satisfied that I understand its content and significance.

It is the policy of T. J. Samson Community Hospital to admit and treat all patients without regard to race, creed, color, or national origin and is an equal opportunity employer.

I have been advised of my Patient Rights and Responsibilities.

_____	_____	_____	_____
Patient's Signature	Date	Witness	Date

_____

Signature of Guarantor, Relationship

Legal Guardian or Closest Relative
Patient is Unable to Sign due to _____

Clerk Initials