MONROE REGIONAL HOSPITAL

MRH MEDICAL GROUP, EAST MAIN CLINIC

CONDITIONS OF TREATMENT AND ADMISSIONS

Patient Name:	Today's Date:
Date of Birth:	Reason for Visit:

Consent to Medical Treatment – I am presenting myself for medical services to the clinic, and I voluntarily consent to the renders of such care, including diagnostic tests and medical treatment by authorized agents and employees of the Clinic and its medical staff or their designees, as may be deemed necessary or beneficial to my well-being.

Consent to Release Information – I hereby authorize the clinic to disclose to insurance companies, including worker's compensation carriers or other parties that may be liable for all or part of the clinic charges, all or part of my clinic records as may be necessary, including any treatment for alcoholic or drug abuse or dependence to determine benefits entitlement and process payment claims for health care services provided. The information released may indicate the presence of a communicable or venereal disease which may include, but not be limited to, diseases such as the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

Special Consent for HIV Testing – The undersigned specifically consents to the testing of the patient's blood or human immunodeficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and / or Hepatitis if determined by the patient's attending physician to be necessary (1) for determining the appropriate and or treatment procedures for the patient or (2) for the protection of the attending physician and / or any employee of the facility exposed to the bodily fluids of the patient in a manner which could transmit such disease. The undersigned has been informed about the nature of the blood test, its expected benefit, and has been given the opportunity to ask questions about the blood test.

Medicare Certification Release – I certify that the information given by me in applying for payment under the Title XVIII and Title XIX of the Social Service Act is correct. I authorize any holder or 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 request that payment of authorized benefits be made on my behalf to the hospital or to the physician who accepts assignment.

Personal Effects and Valuables – I understand that the clinic shall not be liable for the loss or damage of any personal effects or valuables (money, jewelry, glasses, dentures, documents, clothing, etc.).

About Your Bill – I understand that I will receive a bill from the clinic for provision of the medical services, including staff and equipment, and for any supplies or medicines utilized. I understand that MRH Medical Group is drawing for laboratory services, but there will be additional billing from Monroe Regional Hospital for the actual test ran. This will be billed separately from your clinic visit. This signed agreement states that I have been notified of this matter and I agree to the terms.

Insurance Assignment – I hereby assign to and authorize the clinic and physicians involved in care during this period of illness or treatment (herein after-physicians), to take all necessary steps, without limitations, to ensure that any insurance benefits otherwise payable to me or my estate are paid directly to the clinic. This assignment or insurance benefits includes, but is not limited to, billing insurance, filing petitions, filing suit in my name, on behalf of the hospital or physicians, filing proof of claim, filing probate claims and filing grievances and all other similar procedures, as may be awarded from time to time with the State Department of Insurance. I also agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the other purposes.

Statement of Financial Responsibility – I understand that I am financially and legally responsible for charges not covered in full by any third party. I further agree that if I should not pay the balance within thirty (30) days after the date of discharge, my account will be considered delinquent. I agree to pay costs of collection, including reasonable attorney's fees and costs, collection agency fees and costs, and interest which shall accrue at the maximum rate allowed by law.

Fraud Claims Act -- Any person who knowingly and with intent to insure, defraud, or deceive any insurance company or files a statement claim containing false, incomplete, or misleading information, may be subject to prosecution under applicable federal and state laws.

Acknowledgement of Notice of Privacy Practices – A description of how your medical information will be used and disclosed is summarized on the Notice of Privacy Practices. A complete copy of the Facility's Notice of Privacy Practices is posted in the facility and a copy will be provided to you. By signing below, you acknowledge that you have received a copy of the Facility's Notice of Privacy Practices.

Smoking Cessation – I have received information regarding that Monroe Regional Hospital Medical Group _____ is a smoke free facility and that I have received information on Smoking Cessation that I may use or give to someone I know who smokes.

I certify that I have read, understand, and agree with the conditions as stated in this form.

Patient Signature: _____ Date: _____

Legal Guardian: _____ Date: _____ Relationship to Patient: _____

Patient (is a minor child of _____ years of age) OR is unable to consent because: _____

Witness: _____ Date_____