PATIENT NAME: _____

DOB: _____

MRN: _____

DATE: _____

CONSENT FOR TREATMENT AT JEFFERSON COUNTY HEALTH CENTER AND CLINICS

1. **Consent to Health Services:** I am presenting myself for treatment to the Jefferson County Hospital ("Hospital") and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment, by authorized agents and employees of the hospital, and by its medical staff, or their designees, as may, in their professional judgment, be deemed necessary or beneficial. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition. I realize that during the course of my care at the Hospital, or for follow-up care, it may be necessary for the Hospital or my attending physicians to make available to other health care providers information concerning my treatment, including but not limited to, copies of my medical records for information relating to my care, and I consent to such releases.

2. **Personal Valuables:** It is understood and agreed 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, jewel, glasses, dentures, furs, other articles, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping.

3. I also understand that in connection with the Hospital's registration and treatment policies and procedures (including, but not limited to telemedicine procedures), the Hospital may videotape, photograph, or otherwise record the care it provides me, I hereby consent to such video/photograph/telemedicine recordings by the Hospital.

4. **Assignment of Insurance Benefits:** In the event the undersigned is entitled to hospital benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to Hospital for application on the patient's bill. The undersigned and/or patient will be responsible for charges not covered by this agreement. I understand that it may be necessary for the Hospital to release copies of my medical records to my insurance company to determine payment eligibility. I consent to the release of these medical records for this purpose.

5. **Financial Agreement and Payment Guarantee:** Both undersigned patient and the guarantor(s) agree that in consideration of the services to be rendered to the patient, they hereby individually obligate themselves to pay the charges of the hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

6. **For Medicare/Medicaid Beneficiaries Only:** I certify that the information given by me in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished me by, or in, the Hospital, including physicians' services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services ("CMS") and agents any information necessary to determine these benefits or related services.

The undersigned certifies that s/he has read the foregoing, and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. All guarantors certify they have read the foregoing and accept its terms.

I understand that I may revoke the authorization at any time, except to the extent that action has already been in reliance upon it, by giving written notice to the Hospital.

Patient: _____

Patient Representative: _____ **Relationship:** _____