

- **ASSIGNMENT OF BENEFITS:** In consideration of medical services to be rendered to me or at my request, I assign to the Hospital, and to any physicians and other health care providers rendering care to me, to the extent necessary to satisfy any outstanding indebtedness, all sums payable to me or on my behalf pursuant to any health benefit plan, policy of insurance (including, but not limited to, health, liability, uninsured motorist or medical payments insurance) and/or pursuant to any settlement or judgment arising out of or related to any incident which caused the admission or medical treatment. As such payments for Hospital services, and/or physician services, and other health care provider services shall be made directly to the appropriate party previously listed. I understand that neither the Hospital nor any other health care provider has any obligation to collect benefits covered by this Assignment other than benefits payable by a health maintenance organization. Hospital is hereby authorized to act as attorney-in-fact in the collection of benefits from any third party through whatever means may be deemed necessary and in the endorsement of checks made payable to patient and/or the Hospital.
- **APPLICATION OF CREDIT BALANCE:** Credit balances which occur in my favor on this account for whatever reason may be applied by the Hospital to reduce any other outstanding account with the Hospital which I am responsible before refund of any balance remaining.
- **COORDINATION OF BENEFITS:** I hereby authorize the refund of overpaid insurance benefits in accordance with any services are provided by the Hospital, which are subject to a coordination of benefits clause.
- **NON-MEDICARE PATIENTS-RESPONSIBILITY FOR PAYMENT OF THE BILL:** In return for services rendered to the patient or any infant(s) born to the patient, I understand that I owe, and unconditionally agree and promise to pay, the Hospital the full amount charged for these services. I specifically agree to pay for any services, which are determined not to be covered by any health benefit plan or insurance company. I am aware that I am not relieved of liability by any extension of time granted for the payment of these charges, not by the acceptance by the Hospital of a note of the patient or any third person. I also waive the homestead and all other exemptions. The Hospital reserves the right to charge interest at the rate of twelve percent (12%) per annum or one percent (1%) per month for outstanding balances remaining after the normal billing cycle has been completed. If the Hospital requires legal assistance to collect an account, I agree to pay the cost incurred for such collections, including without limitation, an attorney fee equal to twenty-five percent (25%) of all sums due on account. I authorize the Hospital to check my credit and employment history and by this authorization expressly permit sources and employers to provide the Hospital with all information requested.
- **MEDICARE PATIENTS ONLY:** I request that any of my authorized Medicare benefits for any services furnished to me by or in the Hospital be paid. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits. I understand that I am responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.
- **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I have a received a copy of the Notice of Privacy Practices and understand that the notice describes how my medical information may be used and how I can get access to this information. I have also been given an opportunity to ask questions about the information provided in the Notice.

SIGNATURES:

 Print Name (Patient)

 Signature of Patient or Legal Guardian

 Date

 Other person executing form and relationship to patient.

 Hospital Representative:

 Date

(If written acknowledgement of receipt of the Notice of Privacy Practices is not obtained, complete the following):

Written acknowledgment was not obtained for the following reason(s) _____