Med Center Health

The Medical Center at Bowling Green

General Conditions of Admission, Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Procedures and Medical Treatment:
I do voluntarily consent to hospital care involving diagnostic tests, procedures and medical treatment as ordered by my treating physician(s), practitioner(s) and his or her designees. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment in the hospital.

Independent Contractor Acknowledgement:
I understand and acknowledge **the physicians and other practitioners involved in my care, including but not limited to my attending physician, consulting physicians, emergency department physicians, physician assistants, nurse practitioners, radiologists, anesthesiologists, nurse anesthetists and pathologists are not agents or employees of The Medical Center.** I further understand I will be billed separately for services by these providers. These providers have independent relationships with insurance companies, and the hospital makes no guarantee as to any preferred provider relationships with these physicians/practitioners.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to The Medical Center and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by The Medical Center as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by The Medical Center in no way absolves me from liability for any portion of the bill not paid by a third party payer for any reason. In the case of outpatient services, I agree this document shall remain in full force and effect until specifically revoked by me in writing. This writing is intended to be the complete and exclusive statement of the terms and conditions regarding my assignment of benefits and supersedes all previous communications, representations or agreements, whether oral or written. Any terms or conditions proposed by me or on my behalf that differ from or are in addition to the terms of this agreement are rejected and shall not become part of this agreement.

Unless other payment arrangements are approved by The Medical Center, the account balance is due upon demand. Failure to remit payment for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as reflected by the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event a claim is reduced to judgment, it shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree The Medical Center, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

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Release of Information:
I authorize the release of all or part of my records, including information stored in The Medical Center corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my social security number to the manufacturer of any implantable medical device in accordance with the Medical Device Tracking Act of the FDA. I authorize the release of my HIV and hepatitis test results to health care personnel in the event of an occupational exposure.

I authorize the hospital, physicians and any other holder of medical or other information to release any information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) required for the completion of any claim for benefits arising out of services rendered to me either on an inpatient or outpatient basis to any person or corporation which is or may be liable for all or part of the total charge incurred, including but not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by the hospital to make collection of any unpaid hospital charges. I further authorize my employer to release to the hospital or any agency engaged for the purpose of collecting any unpaid hospital charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Hospital Quality and Efficiency Program:
I have been informed that doctors on the medical staff may participate in a program designed to further promote the quality and efficiency of patient care services rendered at The Medical Center. Aspects of my care may be evaluated as part of this program and doctors may be paid related to their performance. I understand that this program will not increase any of my costs or that of any insurer or governmental payor who helps pay for my care. The program is funded solely by The Medical Center as part of its commitment to provide high quality care to the community. I can opt out of this program and/or learn more about it by contacting 270-745-1000.

General Consent to Photograph:
I consent to the taking of pictures, videotapes or other electronic reproductions of my medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for medical treatment or internal or external activities, including but not limited to education, research and quality improvement/risk management, all conducted in accordance with The Medical Center's policies. Photographs containing protected health information will be located in the electronic medical record or otherwise securely stored pursuant to approved policies or practices and remain the property of The Medical Center. I understand and agree that no liability of any nature shall be attached to The Medical Center or any other party in acting pursuant to this authorization.

I do not authorize photographs to be taken.

_____
Signature

Information Received:

_____ (initials) I acknowledge I have been given written information concerning my rights and responsibilities, Advance Directives, AIDS, pain, smoking cessation, portal instructions, and The Medical Center's Notice of Privacy Practices.

_____ _____ _____ _____ _____
Signature *Date* *Time* *Relationship (if not patient)* *Witness*

Original - Chart *Copy - Patient*