JACKSON COUNTY SCHNECK MEMORIAL HOSPITAL
d/b/a Schneck Medical Center

SCHNECK MEDICAL CENTER

General Consent for Treatment,
Release of Information and Financial Responsibility

Please read the entire consent form prior to signing.

1. GENERAL CONSENT FOR TREATMENT

I request and authorize Jackson County Schneck Medical Center ("the Hospital"), its agents and employees, my physicians, their associates and assistants who may attend to me during this hospitalization, emergency service, or outpatient visit, to provide me health care services. Health care services may include but not be limited to things such as specific medical and surgical care, tests, procedures, drug administration, and other services and supplies that are considered advisable by my Physician for my health and well being. I also understand this may include the need for tests ordered by my Physician for communicable diseases such as hepatitis, Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"). I understand the test results will be kept private in my medical chart.

2. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the Hospital to share my personal health information with other people or organizations such as my insurance company and other physicians or health care providers as it relates to my treatment, payment for the care the Hospital or treating physicians provide me and for other health care operations. Health care operations generally include those activities the Hospital performs to improve the quality of care. In addition, the Hospital has my permission to share my personal health information, including but not limited to test and procedure results, with the following individuals: Spouse ____ Children _____ Sibling _____ Other ____
Please specify names(s): _____

The hospital has my permission to let friends and family know that I am here today. YES_____ NO _____

3. PRIVACY INFORMATION

The Hospital has prepared a detailed **NOTICE OF PRIVACY PRACTICES** to help you better understand the Hospital's policies with regards to your personal health information. The terms of the Notice of Privacy Practices may change from time to time. As a result, the Hospital will always post the most current notice at each facility site and on the Hospital website in addition to making copies available for distribution. By signing below, I acknowledge that I have received a copy of the **NOTICE OF PRIVACY PRACTICES**.

4. ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby assign payments otherwise payable to me from Medicare, Medicaid, insurance carriers, employee health benefit plans and other third−party payers (collectively referred to as "Plans") to the Hospital and other health care providers who provide health care services, care or treatment to me on behalf of the Hospital.

I acknowledge that I am responsible for knowing the limitations of my Plan benefits and agree to be personally responsible for paying the charges billed for services, care or treatment that my Plan deems to be: (i) not a covered benefit; (ii) in excess of the Plan's benefit limitation or (iii) not medically necessary, investigational or experimental.

The Hospital will make a reasonable effort to verify my Plan's coverage for the services, care and treatment I expect to receive at the Hospital and to notify me, in advance, of items it knows are not covered benefits. However, should my Plan ultimately deny payment for the services, care and/or treatment provided to me by the Hospital and other health care providers on behalf of the Hospital, I am responsible for paying the billed charges for such items, consistent with any applicable, written, contractual discounts and the Hospital's patient financial assistance policies.

I agree to promptly pay, when requested by the Hospital, the difference between the Hospital's billed charges for the services, care and treatment I received and the amount covered by my Plan benefits, other than those amounts excluded by a written contractual agreement and/or the Hospital's patient financial assistance policies. Upon request, an authorized patient representative will be made available to explain eligibility for financial assistance under such policies.

Except as otherwise prohibited by State or Federal laws, I agree that I will pay for all costs of collection, including reasonable attorney s fees, court costs, and all other expenses incurred by the Hospital and/or other health care providers who provide services to me on behalf of the Hospital in enforcing its rights to payment of my account. I further agree that any credit balances resulting from payment by a Plan or other sources may be applied toward any other account owed by me to the Hospital and/or other health care provider(s) who provided services to me on behalf of the Hospital.

5. INDEPENDENT STATUS OF PHYSICIANS

I understand that physicians who furnish services to me (such as emergency room physicians, radiologists, pathologists, anesthesiologists, etc.) may be independent from the Hospital and will bill and collect for their services independently from the Hospital. I understand that the physician bills provided to me will be separate and apart from the Hospital s billing and collections.

6. PERSONAL PROPERTY

The Hospital will not be responsible for personal property that is not locked in the Security Department's Safe. Families are encouraged to take any personal belongings home during the patient's stay. Please initial here: _____

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THE CONTENTS OF THIS CONSENT DOCUMENT before I signed below.

_____ _____
Date Patient Signature

_____ _____
Witness Signature of Guardian or Representative

CONTX

SCHNECK
MEDICAL CENTER

Discrimination is Against the Law

Schneck Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Schneck Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Schneck Medical Center:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Schneck Medical Center s Compliance Officer.

If you believe that Schneck Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Deborah Mann, Vice President of Finance and Chief Financial Officer
411 West Tipton Street, Seymour, IN 47274
(812) 522−2349
compliance@schneckmed.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Schneck Medical Center s Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1−800−368−1019, 800−537−7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Patient Initials