VAN BUREN COUNTY HOSPITAL
PATIENT SERVICE AGREEMENT

1. CONSENT. I consent to hospital and medical care for myself, or the patient if a personal representative, (or a newborn child in maternity cases), including examinations, tests, photographs, x-rays, therapies, and other procedures deemed appropriate by my physicians, their assistants, or personnel of Van Buren County Hospital ("Hospital"). In the event telemedicine is used to diagnose and treat any condition, I consent to its use by a physician affiliated with the Hospital. Neither Hospital nor any of its employees or agents have made any guarantees regarding the results of any such care. I understand that independent contractors of Hospital may provide services to the patient, including but not limited to providers of anesthesiology and radiology. The physician and/or a member of the nursing staff may ask me to sign an additional form confirming informed consent to any recommended procedure.

2. ASSIGNMENT OF BENEFITS. I hereby absolutely assign to the Hospital for services provided by the Hospital and its employees or others working under contract or arrangement with the Hospital, all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to the Hospital. I further assign and direct payment to Hospital all coverage and benefits available for the services of physicians providing services to the patient at the Hospital. I agree that the Hospital may directly receive benefit payments and discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient or the undersigned. The benefits assigned include, but are not limited to, all benefits for all medical and hospitalization insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid, and TRICARE; benefits payable by alternative delivery systems such as HMOs and PPOs or arising from workers' compensation or occupational disease claims; and proceeds to which the patient, or the patient's estate, is entitled because of any judgment, settlement, or other claim or cause of action for damages against any person or organization if the patient was or is injured.

3. FINANCIAL AGREEMENT. I agree to promptly pay all charges for services and supplies provided by Hospital and others myself, or the patient if a personal representative, in accordance with their regular rates and terms. Except to the extent otherwise provided in paragraphs 4 or 5 below, I hereby personally obligate myself, or the patient if signing as the personal representative, the spouse of the patient or the parent of a minor patient, for payment of all such charges at the regular rates to the extent not covered by insurance or other sources and agree to pay any charges which, for any reason, are not promptly paid by other sources. I understand that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage. No extension, forbearance, or attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges, shall waive my financial obligations hereunder. Any credit balance resulting from benefit payments from insurance or other sources may be applied to any other account owed to Hospital by the patient or the undersigned.

4. MEDICARE PATIENTS ONLY – ASSIGNMENT AND CERTIFICATION. I request payment of authorized Medicare benefits be made on my behalf, or on the patient's behalf if a personal representative, for any services furnished to the patient by or in Hospital. I assign the benefits payable for Hospital or physician services and authorize the Hospital or physician to submit a claim to Medicare for payment. I authorize any holder of medical or other information about myself, or the patient if a personal representative, to release to Medicare and its agents any information needed to determine these benefits or benefits for related Medicare services. I understand that I am responsible for any medical insurance deductible, for 20% of the remaining charges, and for the cost difference of any private accommodation in which I the patient is placed at my request. I certify that all information given by me in applying for payment under Title XVIII of the Social Security Act is correct and complete to the best of my knowledge, and I further certify that the information I have provided the Hospital is true, accurate, and complete.

5. MEDIGAP PATIENTS ONLY – ASSIGNMENT OF MEDIGAP BENEFITS. I request that payment of authorized Medigap benefits be made either to me or on my behalf to Hospital, for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to release to the Medigap Insurance Company named below any information needed to determine these benefits or the benefits payable for related services. Until revoked, this statement applies to all occasions of service.

6. PERSONAL VALUABLES / PROPERTY. I understand that personal property and valuables should be entrusted to a family member or left at home. I unconditionally release and hold harmless Hospital from all responsibility for any personal possessions brought to Hospital.

7. ACKNOWLEDGMENT OF RECEIPT. Patient's initials are to be placed by the line corresponding to each document Hospital has provided to the patient or patient's representative.

_____ I acknowledge receipt of Hospital's Notice of Privacy Practices

_____ I acknowledge receipt of the **IMPORTANT MESSAGE FROM MEDICARE**

_____ I acknowledge receipt of Hospital's notice regarding Patient Rights and Responsibilities

8. PHYSICIAN AVAILABILITY NOTICE. Van Buren County Hospital is a critical access hospital providing for the health care needs of its patients through competent, fully trained staff that are available 24 hours per day. However, Van Buren County Hospital does not provide on-site availability of a physician 24 hours per day, 7 days per week. At times when there are no physicians present, patients with health care emergencies will be assessed and treated by qualified medical personnel. Physicians are readily available by telephone and pager to come to the Hospital. Patients may also be transferred to another hospital when necessary.

9. CONTINUING CARE. Your treatment may require several visits. In such cases, the request, consent, and agreements herein shall apply to all repeat visits and all continuing treatment and diagnosis for the same condition.

10. RELEASE OF INFORMATION – TREATMENT AND PAYMENT. I understand that the Hospital may release and disclose all or any part of the patient's hospital or medical record to any person or entity (or representative thereof) which may be responsible to pay for any portion of the charges incurred, including but not limited to any private insurer, government program, workers' compensation payer, employer, or family member, as necessary for the Hospital to obtain payment for the services provided to the patient. I also understand that the Hospital may disclose to any physicians, hospitals, or others who may require such records in connection with my current or subsequent health care. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this consent.

11. SELF-ADMINISTERED DRUGS - OUTPATIENT ONLY. I understand that self-administered drugs as an outpatient may not be billed to and/or covered by Medicare and Medicaid and may be the patient's responsibility.

12. HOSPITAL DIRECTORY. We will include your name and room number/telephone number in the Hospital's directory. This information may be provided to members of the clergy and to other people who ask for you by name. You have the right to opt out of including your information in the directory. It is important to understand that if you opt out, you will not receive any phone calls (even from family), visitors will be told that you are not here and any flowers or gifts will be sent back. If you want to opt out, you should request to speak to the charge nurse.

13. ADVANCE DIRECTIVE. Do you have an advance directive? _____ Information given (Check one): ☐ **Y** ☐ **N**

14. Patient Visitation Rights- Family and friends are extended the privilege of open visiting hours at the Van Buren County Hospital. These hours, however, may be limited by the patient's physician or nursing personnel, or at the request of the patient and/or his/her immediate family. Please see the full visitor policy pamphlet at each registration desk or ask for additional information.

BY MY SIGNING BELOW, I CERTIFY I HAVE READ, UNDERSTOOD, AND AGREED TO THE ABOVE INFORMATION, AND IF I AM NOT THE PATIENT, I AM AUTHORIZED TO SIGN FOR THE PATIENT.

Medigap Insurance Company:_____ *Medigap Policy Number*:_____

_____	_____ a.m.		_____
Date	*Time*	p.m.	*Patient's Signature*
_____	_____ a.m.		_____
Date	*Time*	p.m.	*Signature of Person with Authority to Consent*
_____			_____
Patient's Name			*Relationship to Patient*
_____			_____
Witness to Signature			*Signature of Second Witness if phone consent*

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