FMC Medical Clinic - Fayette (FMC)

GENERAL CONSENT: A patient's care plan is established by his or her physicians; and, in most instances, the hospital is not liable for any act or omission when following the instructions and/or orders of the patient's physician(s). I consent to any examinations, tests, treatment, procedures, therapies or medications rendered to the patient under the general and special instructions of the physician. I consent to being photographed for clinical purposes. Additional consents may be required for specific examinations, procedures, or therapies.

I understand that most physicians providing services to the patient are independent contractors and are not employees or agents of the hospital. I also understand that I likely will receive separate bills for physicians or other healthcare professionals that may render treatment and services to me.

STATEMENT OF FINANCIAL RESPONSIBILITY: Unless otherwise prohibited, the patient unconditionally guarantees payment in full to DCH Healthcare Authority (DCH), its physicians, and other healthcare professionals that may render treatment and services to me. I understand that any unpaid balance is due in full within 30 days of receipt of the initial statement unless other arrangements for payment are made. The patient further agrees to pay any cost or expense, including court costs and attorney fees associated with the necessary collection of my account. **However, I understand that certain patients may qualify for substantial financial assistance based on individual circumstances and need. This assistance may reduce or eliminate the amounts for which the patient is responsible. Information regarding financial assistance may be obtained by calling 205 343 8321.**

I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) by or to the hospital and by or to any and all healthcare professionals involved in my care; interpretation of test results; account billing and collection; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from this encounter have been fully satisfied. I authorize the hospital and all clinical providers who have provided care or interpreted my tests. I authorize DCH , or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by pre-recorded forms of voice messaging systems, by electronic mail owned by or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received from DCH or payment for services I received at DCH, including but not limited to debt collection purposes. I further understand and acknowledge that my consent in receiving the aforementioned communications is not required nor is it a preceding condition to receiving health care services from DCH.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign and authorize and direct payment to DCH or any other healthcare provider of all insurance benefits, including those provided under Medicare and Medicaid under Title XVIII/XIX of the Social Security Act, payable under their respective terms for my services and medical treatment. Unless otherwise provided by law, the filing or processing of any claim shall not be a condition precedent to any collection of any unpaid charges, and shall not be construed as the assumption of any duty by DCH with regard to the insurance.

To the extent allowed by law, I remain responsible for any portion of the hospital bill not paid by insurance, including co-insurance, denied claims or deductibles or reduced or forgiven under any applicable financial assistance program. I understand that if a private room is requested or provided, I am responsible for any additional unpaid charges incurred.

RELEASE OF INFORMATION: In addition to that provided above, the hospital and its physicians may disclose all or any part of the patient's record when such disclosure is necessary for my continued treatment, the payment for the services I receive, for healthcare operation or as may be required or allowed by applicable law.

For detailed information about how your healthcare information may be used, please review DCH Health System's Notice of Privacy Practices. I permit a copy of these authorizations and assignment to be used in place of the original.

PERSONAL VALUABLES: It is understood and agreed that DCH is not responsible or liable for the loss, theft or damage to any money or any personal property, however described and regardless of the mechanism of loss, unless such property is deposited with the hospital for safekeeping.

AUTHORIZATION FOR MEDICATION ASSISTANCE PROGRAMS: DCH participates in programs with some drug manufacturers that can offer assistance in providing medications for low-income, non- and under-insured patients who meet certain standards. I grant DCH permission to send the patient's medical and financial information to these drug manufacturers for the purposes of applying for aid. I am also granting DCH, or its agents, permission to complete the drug manufacturers' application forms and to sign on the patient's behalf.

Patient Signature _____ Date/Time _____

Patient's Representative (if patient is unable to sign) _____ Date/Time _____ Representative's Relationship to Patient _____

Witness Signature _____ Date/Time _____

If consent is by phone:

Name of Person Giving Consent _____ Relationship to Patient _____

Witness Signature _____ Date/Time _____