Name: Date of Birth: MRN#: CSN:

Consent for Provider Services

1. **Annual Consent for Services:** I consent to the services that may be performed by a Sisters of Mercy Health System ("Mercy") physician/provider ("provider") or facility. I understand I can withdraw my consent at any time.

2. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized I am under the care and supervision of my attending provider and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.

3. **Rules and Regulations:** I understand that my visitors and I must obey all rules and regulations. I understand that in the event all rules and regulations are not followed, Mercy may pursue corrective action.

4. **Notice of Privacy:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NPP is considered part of these Conditions of Admission by this reference. I understand that this notice is only provided the first time I receive services from the hospital and is otherwise available upon request.

5. **Personal Valuables**: I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of unusual value, Mercy is not responsible for the loss or damage to these items.

6. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.

7. **Release of Information:** I authorize Mercy to release the minimum necessary medical and/or billing information concerning my care, including copies of my medical records, electronically or on paper, for the purpose of ongoing medical treatment and billing for services provided. I acknowledge that this authorization is valid for one year, or until all accounts are settled.

8. **Financial Agreement:** I agree to accept financial responsibility for all services provided to me by Mercy. I also agree to promptly pay all hospital and provider bills, in accordance with the applicable rates and terms, which can be modified by agreement between the hospital or provider and my health care insurance company. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. I understand that if my account is delinquent, it will incur interest at the legal rate. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

9. **Assignment of Insurance Benefits:** I assign and authorize direct payment to Mercy of all insurance and plan benefits related to services provided by Mercy. By paying Mercy, my insurance company or employer is fulfilling its obligations under my health insurance policy, or my employer is fulfilling its obligations as required by law. I also understand that I am financially responsible for charges not paid according to this assignment.

10. **Independent Contractor/Providers:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.

11. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

12. **Phone Calls:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone or voice messages and authorize the use of automated dialing technology and pre-recorded messages. I agree such contact will not be "unsolicited" for purposes of local, state or federal law.

13. **Notice to Mercy Co-workers:** As a co-worker employed by an entity owned or controlled by Mercy, I agree to payment of outstanding balances(s) due for medical services rendered to me, or any dependents for whom I am financially responsible, after all applicable insurance payments are received for such services. In the event I do not make reasonable attempts to resolve the outstanding balances, I understand Mercy may initiate payroll deduction, in accordance with Mercy's Co-worker Payroll Deduction Policy.

14. **Patient Self Determination Act:**
    I have an Advance Directive? ___ Yes ___ No

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to execute and accept the terms thereof. A copy of the executed form is available upon request.

Date: _____ Time:_____Signature: _____

If signed by other than patient, indicate relationship: _____

Witness: _____