



## Conditions of Services at Spalding Regional Medical Center 601 S. Eighth Street Griffin, GA 30224

### 1. Financial Responsibility

In consideration of the services rendered or to be rendered to patient, the undersigned, whether he/she is the patient, patient's relative, patient's legal guardian, representative, agent, other individual or entity, hereby obligates himself/herself individually, to the hospital, physicians, surgeons, emergency department physicians, radiologists, pathologists, anesthesiologists, and consultants involved in the patient's care and agrees to pay for any and all charges and expenses incurred or to be incurred. It is agreed and understood that regardless of any and all assigned benefits/monies. I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to the hospital, and the appropriate physicians, surgeons, emergency physicians, radiologists, pathologists, anesthesiologists, and consultants involved in the patient's care and agree to pay for any and all charges and expenses incurred or to be incurred. It is further agreed and understood that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or collection agency for collection or suit, I as the designated responsible party or entity, shall pay all patient charges, reasonable attorney's fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt. All delinquent accounts may be charged interest at the maximum rate allowed by law.

### 2. Assignment of Benefits to Hospital and Hospital-Based Physician

In consideration of the services rendered or to be rendered, I hereby irrevocably assign and transfer to the hospital, and hospital-based physicians (e.g. radiologists, pathologists, anesthesiologists, emergency department physicians) all rights, title and interest in all benefits/monies payable for services/supplies rendered, including but not limited to group medical/indemnity/self-insured/ERISA benefits/coverage, PIP, UIM/UM, auto/homeowner insurance, and in all causes of action against any party or entity that may be responsible for payment of benefits/monies regardless of whether or not I ultimately settle my claim with a non-admission of liability provision. I fully understand that in the event the hospital and/or hospital-based physicians files a claim on my behalf that the same does not impose any contractual obligation or otherwise upon the hospital and/or hospital-based physicians, and that, notwithstanding the irrevocable nature of this Assignment of Cause of Action and Benefits. I remain fully responsible for instituting, and am expressly authorized by the hospital and hospital-based physicians to institute suit within the applicable statutes of limitations. I authorize the hospital and/or hospital-based physicians to appeal any denial under my appeal rights provision. It is hereby agreed and understood that any condition precedent, subsequent or otherwise, including, but not limited to, pre-certification, preauthorization, or second opinions shall remain the sole responsibility of patient and/or the patient's family, legal guardian, representative or agent. I further understand that failure to pre-certify could result in reduced payments from patient's insurance company, leaving the undersigned financially responsible for the non-reimbursed portion of patient's bill. It is further agreed and understood that the obtaining of verification of benefits and/or pre-certification does not in any form or fashion relieve the patient or the patient's family, other individual or entity signing on behalf of patient, of any liability for the financial responsibility for goods and services provided or to be provided to patient by the hospital and/or hospital-based physicians and any other associated physician. I fully understand and agree that hospital and/or hospital-based physicians shall be entitled to full payment where a third-party accident is involved notwithstanding any benefits payable by a managed care payor on my behalf as third-party bears primary responsibility.

### 3. Assignment of Cause of Action and Benefits

I, for good and valuable consideration receipt of which is hereby acknowledged, irrevocably assign and transfer, to the hospital, any and all claims, demands, suits, remedies, guarantees, liens and/or causes of action, at law or in equity, either in contract or in tort, statutory or otherwise, to the extent permitted by law, as well as any other claim, in whole or in part, which I may now have or may hereafter hold or possess, known or unknown, on account of, growing out of, relating to or concerning, whether directly or indirectly, proximately or remotely, any acts, omissions, events, transactions or occurrences that have occurred or failed to occur, which resulted in my injuries for which the hospital has provided and/or will provide medical goods and services to me. This Assignment of Cause of Action and Benefits shall be effective against any and all parties or entities that may bear or appear to bear liability for my injuries, including but not limited to, my employer, its direct and indirect subsidiaries, all of its officers, directors, agents, servants, successors, assigns and employees. I further assign and transfer to the hospital, any and all rights (including appeal rights), title and interest in any and all benefits, monies or other form of compensation paid or to be paid on my behalf as a result of this injury/illness. I fully understand that, notwithstanding the irrevocable nature of this Assignment of Cause of Action and Benefits, I remain solely responsible for instituting, and am expressly authorized by the hospital to institute, suit within the applicable statutes of limitations, and that the hospital is not in any form or fashion responsible for instituting suit on my behalf. I understand and agree that this Assignment does not relieve me of my liability or responsibility for any and all charges incurred as a result of medical goods and services provided to me by the hospital.

### 4. Release of Information/Medical Records

I hereby consent and authorize the hospital and any practitioner, whether agent or independent contractor of hospital, providing medical goods and services to the patient to release information contained in any financial records and/or medical records, including diagnosis and treatment at the hospital or by any practitioner providing medical goods and services to the patient, including, but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory test results, medical history, treatment progress, and/or any other such related information to: (1) Insurance Company, self-funded or health plan, its agents, representatives, attorneys or independent contractors; (2) Medicare; (#) Medicaid; (4) any other person or entity that may be responsible for paying or processing for payment any portion of my hospital bill; (5) to any person or entity affiliated with or representing the hospital and any practitioner providing medical goods and services to patient for the purpose of administration, billing and quality and risk management; or (6) to any other hospital, nursing home, or other health care institution in which the patient is provided treatment. This consent and authorization applies to financial and/or medical records created in the course of and relating to this, or subsequent related hospitalization. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred for treatment at the hospital and by any practitioner providing medical goods and services to patient. I also authorize the release of medical information to organ transplantation services should the patient be identified as a potential organ donor. The content to release medical information is subject to revocation in writing any time, except to the extent that action has been taken. I further understand that unless I otherwise instruct the hospital, in writing, the hospital may release directory information pertaining to me without my consent.

**5. Medicare Patient's Assignment of and Release of Information**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance.

**6. Legal Relationship between Hospital and Physician**

All physicians and surgeons furnishing services to the patient, including the Emergency Department physicians, radiologist, pathologist, anesthesiologist, and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician.

**7. Authorization to Appeal**

I hereby authorize the hospital to appeal on my behalf my claim(s) with \_\_\_\_\_, if applicable, and/or any payor, which denies and/or delays payment of my claim(s). I further authorize that the payors, listed herein and any other payors, release any and all information requested and/or related to my claim(s) to the hospital and/or its attorneys. This authorization is irrevocable upon execution by me herein below and any appeal brought by the hospital shall be as if it was brought by me personally.

**8. Personal Valuables**

It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage of any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The maximum liability of the hospital for loss of any personal property, which is deposited with the hospital for safekeeping, is limited to five hundred dollars (\$500.00) unless a written report for a greater amount has been obtained from the hospital by the patient.

**9. I Have Received the Additional Facility Specific Addendums:**

\_\_\_\_ Patient Rights and Responsibilities  
\_\_\_\_ Important Message from Champus  
\_\_\_\_ Important Message from Medicare  
\_\_\_\_ Authorization to Disclose  
\_\_\_\_ Other Specific Items as listed here:  
\_\_\_\_ I have received stop smoking information including "how to stop smoking" instructions, alternatives to smoking, and follow-up number for additional assistance if needed.  
Patient/Guardian has received Directory Opt Out form and  Chooses to Opt Out (See Directory Opt Out form for specifics)  Does NOT choose to Opt Out

\_\_\_\_ Information regarding Advance Directives  
\_\_\_\_ Not Applicable  
\_\_\_\_ Patient has executed Advance Directives: \_\_\_\_\_ Yes \_\_\_\_\_ No Did you bring a copy? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, whom to contact to receive a copy? \_\_\_\_\_

**10. Organ Donation**

Have you been designated as an Organ Donor? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, where is it documented? \_\_\_\_\_  
If no, do you want to become an organ donor? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Is your family aware of your desire? \_\_\_\_\_ Yes \_\_\_\_\_ No

**11. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative**

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (Paragraph 1) and Assignment of Benefits to Hospital and Hospital-Based Physicians (Paragraph 2) set forth above.

\_\_\_\_\_  
Date Financially / Responsible Party Witness

The undersigned certifies that he/she has read the verbalized/demonstrated understanding of the forgoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

\_\_\_\_\_  
Date Patient/Parent/Guardian/Conservator/Responsible Party--The above conditions of services have been explained to me and I understand.

\_\_\_\_\_  
If other than patient, indicate relationship Witness Witness

A COPY OF THIS DOCUMENT IS TO BE DELIVERED TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT

