AUTHORIZATION FOR PAYMENT/RELEASE OF RESPONSIBILITY

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I certify that information given to me in applying for payment under a Federal, State, Commercial or other Insurance Plan is correct. I hereby authorize any holder of medical or other information about me to release to the applicable insurance carrier or administering entity any information needed for this or any related claim. I request that payment of authorized benefits be made on my behalf.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Franciscan St. James Health and any physician or other health care provider who may treat me to release any and all pertinent information contained in my medical records to other hospitals, clinics, doctors, nurses and healthcare providers who request them for the purpose of my medical diagnosis and care, or to those organizations which pay or manage my medical care. In the event of ambulance transport, medical diagnosis, medical history and treatment information will be released to the ambulance transport service for billing purposes. This release may occur during the hospitalization and/or any time after discharge and will not expire until all claims for this hospitalization are resolved. I understand that this authorization may include information regarding medical, mental health, developmental disabilities, drug or alcohol abuse, or HIV and related diseases. This consent may be revoked at any time by written notice to the Medical Record Department (with no effect on prior disclosures).

PAYMENT FOR SERVICES

I agree, whether I sign as patient or as agent, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the hospital in accordance with the regular rate and terms of the hospital. Should the account be referred to collection I agree to pay any collection expense including attorney's fees.

PATIENT PRE-CERTIFICATION RESPONSIBILITY

I understand that my insurance plan may require pre-certification to authorize this hospitalization. I further understand that if I do not meet my responsibility to obtain pre-certification that I may incur a reduction or loss of paid benefits to the hospital for which I will be financially responsible for.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Franciscan St. James Health of all the hospital insurance benefits payable. I understand that I am financially responsible to the hospital for charges not covered by this assignment.

TELEPHONE / CELL PHONE NUMBER

In order to contact me related to my healthcare and financial arrangements, I authorize Franciscan Alliance, Inc. and its designees to utilize any and all of my contact information (including my email and cell phone) provided to Franciscan Alliance, Inc., or any of its divisions, and utilizing various methods including automated calling, texting and the use of pre-recorded messages.

RELEASE OF RESPONSIBILITY FOR VALUABLES

I also understand that I am fully responsible for all articles (money, hearing aids, jewelry, dentures, eye glasses, etc.) and clothing which I retain in my possession (in my room) and for any other articles and/or clothing which may be brought to me while I am a patient at Franciscan St. James Health. The hospital and employees are not responsible for loss of, or damage to, property which is not specially deposited for safe keeping in the Franciscan St. James Health's vault.

STATEMENT OF UNDERSTANDING: PHYSICIANS ARE NOT EMPLOYEES OF THE HOSPITAL

Franciscan St. James Health is committed to providing its patients with complete information about the care received and believes it is important for you to understand the relationship between the physicians providing that care in the hospital. With the specific exception of certain primary care doctors who are with the medical group of Franciscan Physician Network and are so identified, the physicians who treat you at Franciscan St. James Health are not employees or agents of the hospital. They are independent physicians who, as part of their private practice, see and treat patients of the hospital. These physicians include your private physician or physician from a group who has agreed to treat you if you do not have a physician on-staff at the hospital, as well as doctors that may consult on your care including, but not limited to, radiologists, pathologists, cardiologists, anesthesiologists, surgeons, emergency room physicians, and all other specialists. You acknowledge that the employment or agency status of physicians who treat you are not in any way a reason for nor otherwise relevant to your selection of Franciscan St. James Health for your care. You understand that in most cases you will receive separate bills for services provided by health care professionals affiliated with the hospital. Some of these individuals may not participate in the same insurance plans as the hospital. You may have greater out-of-pocket costs for services provided by out-of-network providers. You should contact your health care plan for questions concerning coverage or benefit levels and for subscriber's certificate of coverage. (_____) Initial

I HAVE READ ALL OF THE ABOVE AND CERTIFY THAT I UNDERSTAND ALL SECTIONS

Patient_____ **Date and Time** _____

Or-Patient's Representative_____ **Witness** _____

Relationship to Patient_____ **Reason Patient Cannot sign** _____

A photostatic copy of this form will be considered a valid authorization.

Franciscan
ST. JAMES HEALTH

AUTHORIZATION FOR PAYMENT/ RELEASE OF RESPONSIBILITY

PATIENT LABEL MUST BE PLACED WITHIN THIS BOX