Consent

(A) RELEASE OF INFORMATION
I acknowledge that records concerning the patient are the property of Sacred Heart Hospital and are maintained for the use and benefit of Sacred Heart Hospital and its staff in providing care and treatment to the patient. I hereby authorize Sacred Heart Hospital to disclose all or any part of my patient records to my admitting physician, consulting physician(s), hospital based physicians. I further authorize Sacred Heart Hospital and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to the Hospital or to me or a family member of mine, for all or part of the Hospital’s charges, including but not limited to, hospital or medical service companies, insurance companies, Worker’s Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations.

(B) ASSIGNMENT OF BENEFITS
I assign payment of all insurance benefits, basic and major medical for this period of medical treatment to be made directly to Sacred Heart Hospital.

(C) FINANCIAL AGREEMENT
For and in consideration of services rendered, each of the undersigned agrees to pay Sacred Heart Hospital for all charges not covered by insurance payments as statements are rendered. Further, should it become necessary to enforce collection of any unpaid balance for medical services rendered, each of the undersigned agrees to pay all collection and legal expenses incurred by the Sacred Heart Hospital including reasonable attorney’s fees which shall include, but not limited to, such fees incurred prior to institution of litigation, or in litigation, including trial and appellate reviews, and in arbitration, bankruptcy, or other administrative or judicial proceedings. Pursuant to Florida Statutes 222.11, the undersigned patient and/or responsible party waives his or her exemption to have disposable earnings of the head of a family which are greater than $500 per week garnished.

(D) STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Sacred Heart Hospital. I authorize any holder of medical or other information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

(E) STATEMENT TO PERMIT PAYMENT OF MEDIGAP BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT
I request that payment of authorized Medigap benefits by made either to me or on my behalf to Sacred Heart Hospital for any services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

(F) AUTHORIZATION FOR MEDICAL CARE AND TREATMENT
1. I recognize that a condition exists requiring medical care and I voluntarily consent to such medical care and treatment, diagnostic procedures by Sacred Heart Hospital and its medical and professional staffs, associates and agents and as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray diagnosis or therapy as he considers necessary and proper in the treatment of the patient.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Sacred Heart Hospital.

(G) ACKNOWLEDGMENT OF HEALTH INFORMATION PRACTICES
The Sacred Heart Hospital Notice of Health Information provides information about how health information about patients may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand the terms of this Notice may change and that a copy of the revised Notice will be posted in all Sacred Heart Hospital facilities. By signing this form, I acknowledge that I have been offered and/or received the Sacred Heart Hospital Notice of Health Information Practices.

(H) The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form.

(I) Termination of care may result from failure to cooperate and/or compliance with Sacred Heart Hospital Policy and Procedure.

__________________________________________  ____________________________
Signature of Patient or Authorized Representative Date  Spouse  Date

__________________________________________
Witness  Date