STERLING
SURGICAL HOSPITAL
The Surgery You Need in the Setting You Want

Patient Label

PATIENT CONSENT AND ACKNOWLEDGEMENT

REFERRING/ADMITTING PHYSICIAN MAY BE AN INVESTOR WITH STERLING SURGICAL HOSPITAL

Radiology readings are billed separately; you may receive a bill from REGIONAL RADIOLOGY.

AUTHORIZATION TO PAY INSURANCE BENEFITS:

For and in consideration of medical services rendered to the patient named herein, I hereby assign and transfer to Sterling Surgical Hospital, hospital-based physicians, attending physicians, and consulting physicians any rights for the payment of medical benefits which I may have under the policy/policies identified by me during registration or any policy which may be determined hereafter to pay benefits otherwise payable to me or to a beneficiary designated in the policy. By this assignment, I authorize payment directly to Sterling Surgical Hospital, hospital-based physicians, attending physicians, and consulting physicians of all medical benefits payable under the aforesaid policy/policies, but not to exceed the hospital's regular charges.

GUARANTEE OF ACCOUNT:

I/We certify that the information given is true and correct to the best of my/our knowledge. I/We understand that bills are payable within sixty (60) days of the date of service. If it becomes necessary for the account to be referred to an attorney or collection agency, the undersigned agrees to pay the reasonable attorney fees and/or collection expenses. I/We agree to be responsible for the payment of all charges of this medical service and hospital-based physicians', attending physicians', and consulting physicians' services rendered to the above-named patient.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Sterling Surgical Hospital and hospital-based physicians to release the information for the occasion of service requested by my insurance company or third party payer for the purpose of obtaining payment for services rendered during this admission and/or to other healthcare providers for the purpose of followup care or evaluation of care. This information may or may not include mental health and/or substance abuse information.

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT:

I hereby authorize Sterling Surgical Hospital and its employees or agents to provide hospital care incidental to this admission including, without limitations, consent to routine diagnostic procedures and medical treatment, which is to include whatever procedures are deemed necessary by the admitting doctor and such other physicians or assistants as he may designate.

CONSENT OF APPEAL:

I hereby authorize the provider and its designated agent and/or legal counsel, as appropriate, to obtain full reimbursement and pursue all appeal/settlement options available to the patient under the terms of the plan or under any statutory provision governing plan, including but not limited to:

1. Appeal processes and procedures with the payer;
2. Appeal processes with relevant state and/or federal regulatory/licensing agency; and/or
3. State or federal legal recourse.

Patient hereby authorizes payer to furnish the provider and/or its agent/legal counsel with pertinent documentation the patient is entitled to, including but not limited to:

1. Plan language and addenda;
2. Certificate of benefits;
3. Documentation of how "usual, customary, reasonable and/or allowable" amounts were calculated under the plan.

PERSONAL VALUABLES:

It is understood and agreed that the hospital shall not be liable for the loss of or damage to any money, jewelry, glasses, documents, dentures, hearing aids, or other articles of unusual value. **VALUABLES ARE NOT TO BE LEFT IN PATIENT'S ROOM.**

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PATIENT CONSENT AND ACKNOWLEDGEMENT (Cont'd)

ADVANCE DIRECTIVES:

I understand that I am not required to have Advance Directives in order to be treated. I have received written information about my rights to formulate Advance Directives. (Please Check)

❑ I have ❑ I have not executed a Durable Power of Attorney for Healthcare

❑ I have ❑ I have not executed a Living Will Copy provided to Sterling Surgical: ❑ Yes ❑ No

GRIEVANCE POLICY *(given in handbook)*: ❑ I have received a copy ❑ I have not received a copy

HEALTH INFORMATION PRACTICES *(given in handbook)*: ❑ I have received a copy ❑ I have not received a copy

CONTRACTED SERVICE PROVIDERS *(given in handbook)*: ❑ I have received a copy ❑ I have not received a copy

PATIENT RIGHTS *(given in handbook)*: ❑ I have received a copy ❑ I have not received a copy

Sterling Surgical Hospital meets the Federal definition of a physician-owned hospital. A list of physicians with ownership interests in the hospital or its affiliated real estate company will be provided upon request.

A photo static copy of this assignment shall be considered effective and valid as the original.

I/WE HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE.

Patient's (or Representative): _____
signature *date* *time*

Person responsible for bill (if other than pt): _____
signature *date* *time*

Witness: _____
signature *date* *time*