NVH MEDICAL CLINIC

108 W. EVANS ST.
P.O. BOX 269
SPENCER, NE 68777

PATIENT'S CERTIFICATION, AUTHORIZATION, AND PAYMENT REQUEST

I hereby give my consent and authorization for medical treatment.

Guarantee of Payment-Release of Information

In consideration of services rendered or to be rendered, I hereby direct that the hospital and/or clinic benefits payable under my insurance contract, be paid to the Niobrara Valley Hospital (NVH). I further agree that should the insurance be insufficient to cover the entire hospital and/or clinic expense, it will be my responsibility to pay the difference. I hereby authorize any provider or other person, any hospital, including the Veteran's Administration, or governmental hospital, any service organization, any insurance company or any other institution or organization to release any information necessary to determine insurance benefits.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration and/or Medicare Program, or its intermediaries or carriers or the Peer Review Organizations, any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF BENEFITS I hereby assign to the NVH for services provided by the hospital and/or clinic, its employees or others working under contract or arrangement with the hospital, all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to the NVH. I further assign to and direct payment to all providers providing services to me at the hospital and billing separately for their services, all coverage and benefits available for the services of such providers and their employees. I agree that the hospital and providers may directly receive benefit payments and discharge the insurer or benefit programs to the extent of such payments. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient or the undersigned. This assignment may not be revoked as to services provided during this hospitalization or clinic visit.

FINANCIAL AGREEMENT I agree to promptly and fully pay all charges for services and supplies provided by the hospital and/or clinic, providers, and others providing services in accordance with their regular rates and terms. Except to the extent otherwise provided in the Medicare section herein. I hereby personally obligate the patient and also personally obligate myself if signing as patient or spouse of the patient, or as parent of a minor patient, for payment of all such charges at the regular rates to the extent not covered by insurance. I agree to pay any charges which for any reason are not promptly paid by insurance. Furthermore, I understand that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage. No extension or forbearance to attempt to obtain payment from insurance or other sources and no delay or lack of diligence in collecting such charges, shall waive or release the personal financial obligations hereunder. I UNDERSTAND AND AGREE THAT LATE PAYMENT CHARGES AT THE RATE OF FOURTEEN PERCENT (14%) PER YEAR WILL BE ADDED MONTHLY TO ALL CHARGES WHICH REMAIN UNPAID 30 DAYS AFTER THE AMOUNT DUE FROM THE PATIENT THE UNDERSIGNED IS DETERMINED AND BILLED.

SIGNED/VERBAL CONSENT GIVEN BY_____PATIENT NAME_____

WITNESS_____DATE_____