NIOBRARA VALLEY HOSPITAL
401 South 5th Street, Lynch, NE
1-402-569-2451
WWW.NVHCARES.ORG

CONSENT FOR TREATMENT AND AGREEMENT TO PAY

Inpatient / Outpatient

Patient Name: PATNAME
Episode#: PATNUM
Adm Date: PATADMIT
DOB: PATBDAY
Attending Dr: PHYS1NAME

I. CONSENT FOR ROUTINE DIAGNOSTIC PROCEDURE AND MEDICAL TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s) at Niobrara Valley Hospital, hereafter referred to as Hospital, including the administration of blood products. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne Infections including Hepatitis B and Caswell as HIV/AIDS. I also consent to the taking of pictures of medical or surgical progress for scientific, education or research purposes. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Hospital.

II. AGREEMENT TO PAY:

I acknowledge and agree that in consideration of the services to be rendered, I am obligating myself to pay for all regular charges, which are contained in the applicable hospital pricelist ("chargemaster") which is in effect on the dates of service rendered, for items or services and treatment provided to me, including any amount not paid by my insurance plan. I understand that I can request additional information about charges for procedures, devices, pharmaceuticals, and other Items or services, or can obtain a non-binding estimate prior, or subsequent, to signing this agreement.

I understand that some items or services that Hospital may provide to me may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services or items or services in excess of the limits in my member benefit agreement. Examples of items or services that may be deemed to be non-covered include private nursing duty, sitr.er services, certain durable medical equipment, personal convenience items, and certain medical supplies. I understand that I am personally responsible for any item or service determined by my third-party payor (my insurance company) non-covered for any reason.

I understand that I am personally responsible for any non-covered Medicare, Medicaid, private Insurance or any third-party carrier Items or services that are typically listed on the financial responsibility for non-covered items or services forms. I understand that I am personally responsible for deductibles and co-Insurance established by my member benefit agreement, including those required for ln-network laboratory and other ancillary services or Items.

I hereby agree that if Hospital has agreed to bill my insurance or other third party carrier, It has agreed to do so as a courtesy, and that Hospital has the right, should Hospital deem It advisable, to demand payment in full from me at any time prior to full payment from my insurance or third party carrier, unless Hospital and my insurance company or third party carrier have agreed that I will net be billed.

I hereby agree that I have been advised that I may be billed by Hospital and that this Assignment of Benefits and Agreement to Pay applies to any and all Hospital physician services and both inpatient and outpatient Hospital accounts. If a delinquent account is referred for collection, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process. All delinquent accounts bear Interest at the legal rate. It is the patient or guarantor's responsibility to carry out insurance company or employer requirements prior to this hospital admission, such as filing additional forms and getting authorizations. Hospital will make every attempt to help you meet those requirements; however, the hospital does not take financial responsibility for non-compliance.

GUARANTOR AGREEMENT -By signing this document as Patient/legal Representative or Guarantor, I hereby agree that all charges connected with this treatment and any other treatment rendered to the above patient past

or future, not covered by any Insurance program, sponsorship or other third-party coverage I may have are due and payable at the time of discharge or discontinuation of treatment. I understand that upon request I may be given a non-binding estimate of my hospital charges.

ASSIGNMENT OF BENEFITS:
I hereby authorize and request ALL Insurance carriers, health maintenance organizations or managed care organizations with whom I have coverage, Including, Medicare and Medicaid, to pay directly to Niobrara Valley Hospital, any and all benefits due under the terms of my policy for items or services provided by Hospital, Including any settlements or Judgments for such Items or services. If my health Insurance will not allow direct payment to Hospital, I agree to Immediately forward to Hospital all health Insurance payments I receive for my care and treatment at Hospital.

VALUABLES RELEASE (for Inpatient and procedural areas only): By signing in the space below as Patient Legal Representative, I acknowledge that I have been given an opportunity to deposit valuables and money for safekeeping. I understand that the hospital assumes no responsibility for personal Items or valuables retained by the patient. Note: Possession of any narcotics or dangerous drugs without a proper prescription Is Illegal; If found, I hereby authorize Its removal and consent to Its destruction.

DISCLOSURES: This facility provides competent, fully trained staff who are available 24 hours per day. The hospital, In some Instances, may not provide on-site availability of a physician 24 hours per day, 7 days per week. At times when there Is no physician present, patients with health care emergencies will! be assessed and treated by qualified medical personnel, with physician support available via telephone or pager, and will be transferred to another hospital, when necessary. Also note that this facility meets the federal definition of a physician-owned hospital. A list of the hospitat l s physician owners *15* available upon request.

RELEASE OF INFORMATION AND PRIVACY NOTICE: I hereby acknowledge receipt of a copy of the "Notice of Privacy Practices" and the Patient Rights and Responsibility." These documents are prepared by Niobrara Valley Hospital for you to understand how your information is handled and what your rights as a patient are. Please check that you have received both documents.

• Patient/Legal Representative Check Here: [ ]

ADVANCED DIRECTIVE ACKNOWLEDGEMENT: I have been Informed that I have a right to make an advance directive, which includes a living will or durable power of attorney for healthcare, In accordance with NE law and Niobrara Valley Hospital Policies. I understand that the terms of any directive that I have executed will be followed by the hospital to the extent permitted by law. I also understand that I am not required to have an Advanced Directive In order to receive medical treatments at this facility.

[ ] **NO** I do not have a Living Will or Durable Power of Attorney for healthcare decisions.

[ ] **YES,** I have a Living Will or Durable Power of Attorney.

[ ] *I have produced an advance directive for Inclusion In my medical record.*

[ ] *I do not have my advance directive copy with me, but I have been Instructed to bring a copy to the hospital for Inclusion In my medical record.*

PLEASE READ THIS ENTIRE AUTHORIZATION PRIOR TO SIGNING.
I certify that I, the patient or authorized legal representative, have read this "Consent for Treatment and Agreement to Pay" and agree to be bound by the terms of this document.

PATIENT SIGNATURE **DATE/TIME**

WITNESS SIGNATURE

ER DEPT. MEDICAID NOTE: PCP REFERRAL/AUTHORIZATION RESPONSIBILITIES - if your Medicaid Primary Care Provider {PCP} did not refer you to this facility and after a medical screening It Is found that this Is NOT an emergency medical condition, then Medicaid may not cover your **visit.** This means you, the patient, may be billed for non-covered services provided by this facility.

•Please check here that the Medicaid PCP Information has been verbally explained to you: [ ]
COPIES Of THIS STATEMENT SHALL BE AS VAUD AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE IN THE HOSPITAL MEDICAL RECORD