PATIENT REGISTRATION and CONSENT FOR MEDICAL TREATMENT

CONSENT FOR HEALTH CARE SERVICES, I suffering from a condition requiring hospital inpatient or outpatient (clinic, radiology, lab services) medical care, hereby voluntarily consent to the rendering of care, which may include routine services, diagnostic procedures, medical treatment, or other medical care and services as the attending providers or others holding clinical privileges at Rio Grande Hospital and Clinics (the "Hospital") consider necessary, and performed by the employees and staff of the hospital and/or physicians, and allied health professionals providing services at the hospital or clinic.

PAYMENT AGREEMENT: I understand that there is no guarantee or reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the hospital and/or clinic of providers rendering services not otherwise paid by my health insurance or other payor. All charges are due and payable upon receipt of the bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any refund that I may be owed will be forwarded to the address on file with the hospital.

AUTHORIZATION FOR RELEASE OF INFORMATION: I give my consent for the hospital/clinic and my providers to release information from my medical records according to the categories listed in the Notice of Privacy Practices.

By checking one of the boxes below, I acknowledge:

- ☐ I have received the Notice of Privacy Practices
- ☐ I already have a copy
- ☐ I have refused receipt of the Notice of Privacy Practices

ASSIGNMENT OF INSURANCE BENEFITS: I authorize and direct that payment of any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the hospital and my providers, to include any clinic services, hospital-based radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible to the hospital or my providers for charges not covered or paid pursuant to this authorization.

PREAUTHORIZATION: I understand that it is my sole responsibility to obtain preauthorization and to comply with all the requirements any medical insurance plan may have, under which I am relying for coverage of the hospital and/or clinic charges.

MEDICARE AND MEDICAID: I certify that the information given by me in applying for payment under the Medicare and/or Medicaid program(s) is correct. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits directly to the hospital on my behalf for services rendered.

PHOTOGRAPH: I authorize the attending physician or other designated person(s) to take photographs for identification purposes and appropriate parts of my body in order to provide supporting documentation of my medical condition. I understand that any photographs taken will be placed in and will remain part of my medical record.

I ACKNOWLEDE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF, I FURTHER ACKNOWLEGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

PATIENT NAME	**DATE OF BIRTH**
PATIENT/AUTHORIZED PERSON SIGNATURE (relationship to patient)	**DATE/TIME**
WITNESS SIGNATURE	**DATE/TIME**