Clinical Services [illegible]

☐ OUTPATIENT

☐ Lab	☐ X-Ray	☐ RT	☐ PT	☐ INPATIENT
☐ EKG	☐ CT/MRI	☐ Echo	☐ OT	☐ OBSERVATION
	☐ Ultrasound	☐ Treadmill	☐ ST	☐ EMERGENCY ROOM

Consent to Treatment: I/We consent to the procedures that may be performed in connection with emergency treatment, inpatient, and/or outpatient treatment, which may include, but is not limited to, routine diagnostic procedures, transportation within the hospital, nursing care and other hospital services provided to the patient and under the general instructions of the patient's physician(s) and other providers on the hospital medical staff including independent contractors. I/We acknowledge that no guarantees have been made regarding the outcome of the care. If the patient is unable to give consent, implied consent to treatment is understood.

Students: I/We recognize that Mineral Community Hospital (MCH) participates in various medical and paramedical training programs involving students. Students from these programs may participate with qualified personnel in my care.

Release of Information: I/We grant MCH and its providers (physician, surgeon, radiologist, anesthesiologist, pathologist and/or other healthcare specialists with MCH medical staff privileges) the authorization to release medical and account information necessary for treatment, payment and healthcare operations. This information may be released to insurance companies, attending/consulting physicians, government programs and/or medical review organizations. See Notice of Privacy Practices.

Acknowledgment of "Notice of Privacy Practices": I/We acknowledge that the "Notice of Information/Privacy Practices" was offered to me during my first visit to MCH on or after April 14, 2003. Another copy will be provided to me at any time upon my request, as required under the Health Insurance Portability and Accountability Act (HIPAA).

Assignment of Benefits: I/We authorize my/our insurance company(s) to make payment(s) directly to MCH and its providers (physician, surgeon, radiologist, anesthesiologist, pathologist and/or other healthcare specialists with MCH medical staff privileges) for benefits covered by my/our insurance contract. Providers may maintain separate billing and collection practices.

Financial Agreement: I/We agree, whether signing as agent or patient, that, in consideration of services to be rendered to the patient, I/We hereby obligate to pay the account of the hospital in accordance with the regular rates and terms of the hospital. The person(s) legally and financially responsible for the patient's medical bills is known as the "Guarantor."

No Guarantee of Cure: I/We acknowledge that no guarantees have been made as to the result of examination or treatment provided in this hospital, whether outpatient or inpatient, and further understand that I may be released from the hospital before all medical problems are known or treated and that it is the my responsibility to make arrangements for follow-up care.

Personal Valuables: I/We acknowledge that MCH shall not be liable for the loss or damage to any money, valuables, or other articles of unusual value, or any personal property unless it has been deposited with the appropriate staff for safekeeping.

Insurance Disclaimer: If covered by an insurance company that requires pre-authorization prior to service, it is my responsibility to obtain such pre-authorization from my insurance company. I/We understand the liability for any charges and/or penalties incurred should my health insurance company deny payment for my hospital services.

Acknowledgment of Advance Directives: I have the right to Advance Directives and may receive written information regarding these choices upon request.

Visitation Rights: I understand that MCH will respect my right to choose who may visit me, as well as my right to withdraw such consent at any time, while I am under the care of MCH; regardless of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. In medically appropriate circumstances, MCH may restrict some visitation.

CERTIFICATION BY RESPONSIBLE PARTY:

This form has been fully explained to me. I have read and understand the contents. A copy will be provided upon request.

______________________________ ______________________________

Name of Patient/Authorized Person /Guarantor — Relationship to patient (where applicable)

______________________________ ______________________________

Date — Witness

"This institution is an equal opportunity provider"

Mineral Community Hospital
P.O. Box 66 Superior, Montana 59872

CONDITIONS OF ADMISSION

Patient's Name:
Date of Birth:
Room #:
Provider:
Hospital #:

Revision Date 4/27/2011