DODGE COUNTY HOSPITAL
Eastman, Georgia

F-129

CONDITIONS OF ADMISSIONS

AUTHORIZATION OF TREATMENT

1. The undersigned hereby authorizes the Dodge County Hospital to furnish the necessary treatments, surgical operation, anesthesia (either local or general), x-ray examination or treatment, drugs and supplies as may be ordered or requested by the doctor in charge, including whole blood derivatives.

2. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatments, examinations or medical care in the hospital.

3. I hereby authorize the hospital and any of its physicians, agents or employees to retain, preserve and use for scientific for teaching purposes or dispose of at their convenience any specimens or tissues taken from the patient's body during hospitalization.

4. I understand that students in the teaching program which utilize the hospital facilities will observe or participate along with members of the professional staff who are directly responsible for the patients care.

FINANCIAL AGREEMENT: The undersigned agrees, whether he signed as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or agency for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

ASSIGNMENT OF BENEFITS: I hereby assign, transfer, and set over to Dodge County Hospital all of my rights, title, and interest to my medical reimbursement benefits and instruct my insurance carrier to make payment directly to Dodge County hospital for the HOSPITAL AND PHYSICIAN expense and benefits separately itemized, otherwise payable to me: But not to exceed the hospital's or physician's usual charges for the services rendered. I understand that I am financially responsible to Dodge County Hospital for charges not covered by this assignment and agree to pay within 60 days of date of service. I further authorize and instruct my insurance carrier to make payment directly to any radiologist, anesthesiology, pathologist, any benefits otherwise payable to me should such physicians be responsible for collection of their own charges.

PERSONAL VALUES: It is understood and agreed that the hospital maintain a safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, or documents, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping.

RELEASE FOR RESPONSIBILITY FOR DISCHARGE

I hereby certify if the patient should leave the hospital for any reason whatsoever, without the written consent of the patient's physicians, the patient and/or the family of the patient hereby relieves the said hospital and physician from any and all responsibility that may result from such action of removing the patient from the hospital.

AUTHORIZATION TO DISCLOSE INFORMATION

The undersigned hereby authorized the Dodge County Hospital to release any information about me including alcohol, drug abuse, and/or psychiatric records relating to my treatment may be necessary for the completion of my insurance claim to insurance company or companies or their agents, Blue Cross / Blue Shield, Medicare Bureau Health Care Financing Administration or its intermediaries or carriers, Medicaid program or its intermediaries or carriers. I also authorize the release of Medical Records including alcohol, drug abuse, and/or psychiatric records to any Professional Review Organization, social agency, or transfer facility or physician.

NEWS MEDIA RELEASE YES ( ) NO ( )

This form has been explained to me and I certify that I understand its contents.

I also understand and agree that this agreement constitutes a simple written contract pursuant to Georgia Law (O.C.G.A. §9-3-24) so as to allow the enforcement of this agreement for a period of six (6) years.

_____ _____

Witness Signature or Patient nearest relative

_____ _____

Date Relationship