PATIENT ACCOUNT: _____
NAME: _____
DOB: _____

ABBEVILLE AREA MEDICAL CENTER

CONDITIONS FOR SERVICES AT ABBEVILLE AREA MEDICAL CENTER

CONSENT FOR THE TREATMENT: The patient's care is under the control of his/her attending physician(s) and the undersigned consents to any x-ray examination, laboratory procedures, medical or surgical treatment or hospital services rendered to the patient under the general and special instructions of the physician(s). The undersigned recognizes that doctors who may furnish services to or on behalf of the patient, including, but not limited to, the radiologist, pathologist, and anesthesia providers may be independent contractors, and not employees or agents of the Hospital. I further consent to the testing for infectious diseases, such as, but not limited to, syphilis, hepatitis, and AIDS, and I further consent to the testing of drugs if deemed advisable by my physician. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of his/her patient rights and responsibilities and the availability of a Patient Financial Counselor.

ACKNOWLEDGEMENT FOR RELEASE OF MEDICAL INFORMATION: In compliance with Federal and State regulations, I consent to the release or any and all of my Protected Health Information to Abbeville Area Medical Center (AAMC) and/or my attending and consulting physician(s) (including, but limited to, radiologists, pathologists and anesthesia providers) necessary for treatment, payment and operations including follow up care. AAMC and/or my attending and consulting physician(s) are authorized to release any medical information required in the processing of applications for financial coverage for services rendered during this admission. I permit a copy of this authorization to be used in place of the original.

GUARANTEE AND ASSIGNMENT OF INSURANCE BENEFITS: I hereby guarantee payment to AAMC and/or my attending and consulting physician(s) for all charges and services incurred during this encounter. I do hereby assign AAMC and/or my attending and consulting physician(s), any and all medical insurance, health benefits, hospital benefits, sick benefits, injury benefits and settlement proceeds due or payable because of liability of a third party, payable by any party, organization or insurance company, or other sources of payment, unless I pay this account in full upon discharge, (the "Assignment"). I hereby authorize and request AAMC and/or my attending and consulting physician(s), to release and furnish medical information, necessary to support claims submitted to any entities for payment, pursuant to the above Assignment. I do hereby appoint and assign to AAMC and/or my attending and consulting physician(s) as my true and lawful attorneys in fact, to act on my behalf, with the full power and authority to collect any and all charges incurred for the benefit of the patient pursuant to the assignment of benefits set forth above. You agree, in order for us to collect any amounts you may owe, we or an associated third party may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

PERSONAL VALUABLES RELEASE: I have been requested to check my valuables with the hospital and hereby release AAMC of any liability an assume responsibility myself for any items not deposited to the hospital's care. AAMC will not be liable for any valuables not claimed within (30) days of discharge.

I have a Living Will (LW) ___Yes___No
I have a Healthcare Power of Attorney (HPOA) ___Yes___No
I would like assistance or more information regarding LW/HPOA ___Yes___No
I have been informed and have been given the opportunity to receive written material on LW/HPOA ___Yes___No
I understand that it is not required to have a LW/HPOA in order to receive treatment/services at AAMC ___Yes___No
I have been informed and have been given the opportunity to receive a copy of AAMC Notice of Privacy Practices ___Yes ___No
I have received a copy of the Patient's Rights and Responsibilites ___Yes_____ DATE
I have received a copy of the "Rights and Protections Against Surprises Medical Bills" _____ (initial)
By signing below, the undersigned certifies the information provided is corrected and the conditions of services are accepted.

Date/Time	Signature of Patient (Parent or Legal Guardian)	Relationship to Patient

Consent for services: ___ Verbal _____ ___ Unable to consent, notified nurse

Date/Time	1st Signature of Witness	2nd Signature of Witness