ACKNOWLEDGEMENT AND CONSENT FOR TREATMENT

AUTHORIZATION FOR TREATMENT: I hereby consent to diagnosis, examination, and treatment at Stanly Medical Services ("SMS") and to the rendering of such care, including emergency services, diagnostic procedures, surgical and medical treatment, by authorized members of the medical staff of SMS or their designees, as they deem necessary in their professional judgment. I understand the following:

- Other healthcare personnel, such as students in various health-related training programs, may participate in my care or observe special procedures;
- No individual shall be subject to discrimination or denied the benefits of any of the services, programs, or activities of SMS based upon race, color, religion, national origin, sex, age, disability, or source of payment.

RELEASE OF INFORMATION: SMS, licensed physicians, and other health care practitioners involved in providing services to me at SMS are authorized to use and release my medical information (except psychotherapy notes) obtained during this visit/registration for purposes of treatment, payment, and health care operations as stated in the Joint Notice of Privacy Practices for SMS and its medical staff. I understand that my medical information could include medical history or information regarding first time diagnosis or treatment of me for a communicable disease (such as sexually transmitted diseases, HIV/AIDS, tuberculosis or hepatitis), mental illness, alcohol or substance abuse. This information may be released to the following:

- Insurance or managed care companies, Medicare, Medicaid, workers' compensation, or other payors whom I identify as possibly responsible for payment of the services that have been provided;
- Independent physicians or health care practitioners involved in my care;
- Persons or agencies involved in processing applications for or determining my eligibility for financial benefits;
- Any person or external review agency involved in reviewing, authorizing, or processing my eligibility for health insurance coverage, payment of benefits, or billing compliance for such potential payors that may be identified;
- National or regional registries or quality improvement organizations;
- Emergency transport services that transport me to or from SMS;
- Persons, physician practices, facilities, or agencies to which I am referred that represent to SMS that I have been referred to them for treatment, that are contacted concerning, or otherwise assist with, providing appropriate care for me during or after my stay;
- Persons at my home, other designated location, or number that I may provide (including telephone, e-mail, or mail) for calls or messages to me or my representative concerning appointment reminders, follow-up, or requests for a return call;
- Family or persons that I or my representative may involve in my care;
- Agencies of the North Carolina Department of Health and Human Services.

FINANCIAL AGREEMENT: I authorize payment and unconditionally assign any insurance benefits directly to SMS and to all treating and consulting physician(s) and entities accepting assignment of all hospital and medical benefits applicable and otherwise payable to me for the services rendered by SMS and such physician(s) and entities. Where Medicare or Medicaid benefits are applicable, I certify that the information I have given in applying for payment under Title XVIII or Title XlX of the Social Security Act is correct, and I request that payment of authorized benefits be made on my behalf. I authorize payment of any refund that is due of any overpaid insurance benefits to the appropriate payer in accordance with my insurance policy provisions under which my coverages are subject to a coordination of benefits clause. If I am owed a refund, I authorize the immediate application of any such refund to any amount that I am personally legally obligated to pay for care and services provided by SMS. If collection efforts are needed to obtain payment from me, I agree to pay the costs of such collection efforts, including reasonable attorneys' fees. I understand that I am financially responsible for and agree to pay and guarantee payment in full of all charges for services provided to me by SMS and independent physicians or other health care practitioners involved in my treatment at SMS, even if such treatment is not covered by insurance. I authorize SMS and the applicable County Department of Social Services (e.g., Stanly, Montgomery, Anson, etc.) to discuss information about me in the event I apply for financial assistance, including Medicaid. I have received the document titled "*An lmportant Message from TRICARE*" or "*An Important Message from Medicare*" at the time of my admission.

PERSONAL VALUABLES: I hereby release SMS from any responsibility for any valuables, money, or other personal possessions which are not identified by me and accepted by SMS for safekeeping.

I certify that I have had the opportunity to read or receive a copy of the Joint Notice of Privacy Practices.

_____	_____	_____
Print Name of Patient	Signature of Patient or Authorized Representative	Date

If a Representative signs for Patient, print the Representative's name and describe the authority to act on behalf of Patient:

_____

(Also, attach a copy of any documentation of Representative's legal authority, e.g., appointment as power of attorney or guardian, order of custody of minor, etc.)

If different from Patient/Representative:

_____	_____	_____
Print Name of Insured/Guarantor/Responsible Party	Signature of Insured/Guarantor/Responsible Party	Date
_____	_____	_____
Print Name of Witness	Signature of Witness	Date

CONSENT OBTAINED BY TELEPHONE

Print Name of Person Called: _____ Telephone Number: _____ Date: _____ Time: _____

Relationship to Patient: _____ Remarks: _____

Consent Granted: Yes No Print Name & Title of 2 Witnesses: 1 _____ 2 _____

rev. 6/10

Patient Label

Stanly
Medical Services