Patient Label

ALTUS HOSPITAL

PATIENT AUTHORIZATION & RESPONSIBILITY FORM

I, the undersigned, in consideration of the provision of medical services by Altus Baytown Hospital (Facility), hereby acknowledge agree to the following terms and conditions.

CONSENT TO PROCEDURE

I hereby consent to and authorize the Facility to perform the procedure in accordance with the general and special instructions of my treating physician or the physician supervising the procedure. I also acknowledge that my physician has fully explained to me the procedure and all risks, benefits and any alternative procedures.

AUTHORIZATION ASSIGNEMENT OF BENEFITS

I hereby authorize and assign payment of any benefits due me under terms of any insurance policy or policies that may cover the procedure performed on me or my dependent(s) by Facility directly to Facility at the address designated by Facility on nay claim form submitted to my insurance carrier. I agree that payment to Facility pursuant to this authorization/assignment by my insurance company shall discharge aid insurance company of any and all obligations under the policy to the extent of such payment. I understand and agree that I am financially responsible for charges not covered by this authorization/assignment and I authorize Facility to contact my employer for purpose of determining the existence of any insurance benefits.

FINANCIAL RESPONSIILTY

I understand that my insurance company is being billed as a courtesy and I agree that I am financially responsible to pay for any charges not covered by my insurance company and/or co-insurance, deductible, co-pay amounts that are outstanding. I agree that any charges which are not paid within thirty (30) days after their due date shall bear interest at a rate equal to the lesser of (i) one and one-half percent (1.50%) per month; or (ii) the maximum rate or interest that can be charged under the law or the State of Texas, or to the extent applicable, under the laws of the United States of America.

NO RESPONSIBILITY FOR VALUABLES

I hereby understand and acknowledge that the Facility is not responsible for the loss of, damage to, or theft of any of my, or my dependent's possessions, including, but not limited to money, jewelry, clothing or valua bles, while I or my dependents are on Facility premises.

SPECIAL NEEDS

I acknowledge and agree that if I receive special needs, such as a wheelchair, etc., the Facility shall not be held responsible or liable for giving or furnishing assistance in connection with my special needs unless such responsibility or liability is imposed by law (including the Americans with Disabilities Act) and cannot be contractually waived or released.

AUTHORIZATION TO RELEASE INFORMATION TO CENTER

I hereby authorize an insurance company, prepayment organization, employer, hospital, physician, or utilization review representative to releases to Facility and authorize Facility to release to any of the same entities any and all information with respect to me or my dependent(s) which may have a bearing if any benefits payable by my insurance company for the procedure performed by Facility on me or my dependent(s). I agree that this authorization shall remain effective for one (1) year from the date indicated below.

Upon enquiry, Facility may make to a public agency or other date collection organization certain basic information about the patient including sex, age, weight, general description of the reason of the procedure. I understand that this consent is valid is valid for one (1) year from the date below and that I have a right to a copy of this form. In the event that tie patient is involved in a worker's compensation or personal injury case, my attorney(s) and worker's compensation board be provided with this information if requested. I hereby release Facility from all responsibility or liability that may arise from release of above information.

_____	_____	_____
Patients Name (Printed)	Patients Signature	Date