MEMORIAL HOSPITAL
UNION COUNTY
Committed to care. Devoted to caring.

FINANCIAL ASSIGNMENT AND AUTHORIZATION

I hereby assign and authorize payment directly to Hospital, the attending physicians and/or their designate, of all insurance benefits and guarantee to pay any balance. I understand that I am responsible for all charges (hospital and/or physician) until the bills are paid in full and for the balance of charges not covered by insurance. Should my account become delinquent, I agree to pay interest at the legal rate, from date of discharge.

I authorize the Hospital to obtain a consumer report for purposes related to financial assistance consideration or the extension of credit.

No action by the Hospital shall relieve me of my sole responsibility to fulfill all obligations under any applicable insurance I may have, including my obligation to verify insurance coverage and my obligation to obtain any required pre-admission certification (inpatient or outpatient). I understand that as a patient I may receive services, ordered by my physician, from certain Specialists who charge separately from the Hospital. These professional corporations are acting as independent contractors and are not employees of the hospital. This Assignment and Authorization is valid and enforceable regardless of any provision to the contrary in my health plan and is governed by Ohio Law.

MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize any holder including the attending physicians and/or their designees, of medical or other information about me to release to the Social Security Administration and/or the Medicare program any information needed for this or a related Medicare claim.

IF FOR ANY REASON MEDICARE OR MY INSURANCE COMPANY DENIES PAYMENT, I AUTHORIZE HOSPITAL TO ACT ON MY BEHALF TO APPEAL FOR PAYMENT.

RELEASE OF INFORMATION

I hereby consent to Hospital disclosing and/or using any or all of the information in my medical records, including but not limited to information pertaining to a diagnosis of or treatment for mental illness, alcohol or drug abuse, HIV, AIDS, or any AIDS related condition, for purposes of my treatment, payment of my health care expenses, or for Hospital health care operations.

PHOTOGRAPHS, VIDEOTAPES, DIGITAL OR OTHER IMAGES

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that the Hospital will retain the ownership rights to these images but I will be allowed access to view them or obtain copies.

CONSENT TO TREAT

I, the undersigned have a condition requiring hospital care, and do hereby voluntarily consent to diagnostic procedures, routine medical treatment, and any admission to the hospital considered necessary in the judgment of my physician. This consent includes any test or procedure for infection control purposes and the release of the results in strict confidence to medical staff or health care agencies and professionals.

I understand that in the absence of an emergency, no substantial procedure will be performed unless I have had the opportunity to discuss them with a physician.

I understand that the physicians who render professional services to me in the hospital may be independent practitioners and are not employees or agents of the Hospital. Hospital is not responsible for the acts or omissions of physicians that are not directed or controlled by Hospital.

_____	_____	_____	_____
WITNESS	DATE	PATIENT / OR LEGAL REPRESENTATIVE'S SIGNATURE	D.O.B.

Reason for signature by person authorized to sign for patient in lieu of signature of patient:

☐ Minor (Under 18 years) ☐ Mental Condition ☐ Physical Condition ☐ Verbal Consent ☐ Telephone Consent

_____	_____	_____
Patient Name	Obtained From	Relationship

_____	_____	_____	_____
Witness	Witness	Phone Number	Date

STATEMENT OF ACKNOWLEDGEMENT

- I hereby acknowledge that I have been offered a copy of Memorial Hospital of Union County's list of charges as required by HB 197 Sec. 3727.42 at no charge.
- I hereby acknowledge that Memorial Hospital of Union County does not accept responsibility for any lost, stolen or damaged personal items. I accept responsibility for those items I choose to keep with me at Memorial Hospital.
- I hereby acknowledge that if I leave the Hospital against medical advice, I will not hold the Hospital or any individual responsible for any of the consequences and I understand I may be personally responsible for my bill.
- I hereby acknowledge that I had the opportunity to review Memorial Hospital of Union County's Notice of Privacy Practices.
- I hereby acknowledge that I will be included in the hospital directory unless I choose otherwise. I understand that "opting out" of the directory excludes me from receiving telephone calls and visitors. ☐ Yes, I choose to "opt out" of the hospital directory.

Form eRE-02

Patient/Responsible Party Initials ☐

Patient Rights & Responsibilities Statement

Memorial Hospital of Union County respects the rights of all of our patients. We are committed to providing you with the utmost considerate and respectful care, as we strive to meet your healthcare needs. In order to provide you with a positive experience, we want you to understand your rights and your responsibilities as our patient.

As a patient of Memorial Hospital of Union County you have the right:

- To receive care regardless of your race, creed, color, national origin, gender, age, sexual orientation, disability, religion or the ability to pay for services.
- To have your cultural, psychosocial, spiritual, personal values, beliefs and/or preferences respected and to exercise those cultural/spiritual beliefs that do not interfere with your care and/or the well being of others. And to have access to clergy.
- To have your personal dignity respected and receive considerate and respectful care at all times.
- To have and receive the visitors that you designate, including but not limited to a spouse, a domestic partner (including a same sex partner), another family member or friend. You may also deny visitors at any time. Visitation privileges will not be denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.
- To have all visitors you designate enjoy visitation privileges that are no more restrictive than those immediate family members would enjoy.
- To be informed of visitation rights including any clinical restrictions or limitations.
- To be protected from neglect, exploitation, harassment and abuse when you receive care, treatment and service.
- To have access to protective and advocacy services.
- To enjoy and be examined in surroundings designed to assure your reasonable personal privacy and a safe environment that promotes a positive self-image and preserves your dignity.
- To understand your diagnosis, condition and treatment and receive this information in a manner that you can understand.
- To have an interpreter provided for you if you are deaf or do not speak English.
- To make informed decisions about your care including, being involved in decisions that affect your care, services, and/or treatment and be involved in the development and implementation of your plan of care.
- To have your pain appropriately assessed and managed accordingly.
- To be free from any forms of restraint or seclusion of any form that is not medically necessary or that is imposed as means of convenience, discipline, coercion or retaliation.
- To complete Advance Directive documents and have them followed in both inpatient and outpatient settings. This may include legally appointing someone to make decisions for you if you should become unable to do so.
- To have your family, a representative of your choice and/or your family physician notified promptly of your hospital admission.
- To have your family or designated representative involved in your care, treatment, and service decisions as applicable and allowed by law.
- To know the names and professional titles of your physicians and caregivers. Also to have the right to request a change in physicians, caregivers, and/or request a second opinion if you choose.
- To know that the confidentiality of your clinical and personal records will be maintained.
- To review your medical record in a reasonable timeframe.
- To express concerns, complaints, and/or grievances regarding your care to hospital personnel. Should you have grievance, you may contact a staff member, the director of the department in which you are seeking care or by calling the Customer Service Director 937-578-2355 or contact ODH 800-342-0553.
- To be provided with information about your continuing healthcare needs and planning for your care after you leave the hospital.
- To have a copy of your itemized bill sent to you and have charges explained to you that you are responsible for. If you should have questions, you can contact our Business Office at 937-578-2708, for any concerns.

As a patient of Memorial Hospital of Union County you have the following responsibilities:

- To provide accurate and complete information about all matters pertaining to your health, including medications, past or present medical problems, insurance information, etc.
- To follow instructions and follow the advice of your healthcare team. If you refuse treatment or do not follow instructions or advice given, you must accept the consequences of your actions.
- To tell members of your healthcare team if you do not understand information about your care or treatment.
- To inform your healthcare team of existing Advance Directive documents or designate a person to speak on your behalf and authorize treatment for you in the event of incapacity.
- To tell your healthcare team of any changes in your condition and/or symptoms you are experiencing, including pain.
- To act in a considerate and cooperative manner and respect the rights and property of others and Memorial Hospital of Union County.
- For outpatients, you are expected to keep your scheduled appointments or cancel them in advance if at all possible.
- To pay your bills or make arrangements with Memorial Hospital of Union County to meet your financial obligations.