Jupiter Medical Center
Jupiter, FL. 33458

MR#:

DOB: / /

For and in consideration of the hospital services and supplies rendered, or to be rendered by Jupiter Medical Center (hereinafter referred to as "JMC") to the patient named above, I agree as follows:

I. **CONSENT TO TREATMENT**: The undersigned, as the patient or as the guardian or representative of the patient, consents to any emergency, medical, surgical, diagnostic or therapeutic treatment, x-ray examination, laboratory procedure, anesthesia or hospital service rendered to the patient under the general or special instructions of a licensed physician or other health care practitioner who is authorized by law to issue said instructions.

II. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby irrevocably assign and transfer to JMC all rights, title and interest to any and all benefits payable for the hospital services and supplies. I specifically instruct my PIP carriers to pay JMC'S claim up to policy limits prior to honoring any wage claim by me or any claim by any other provider. The undersigned hereby directs all payors that may be liable for the hospital services and supplies to pay directly to JMC all benefits due as a result of their liability by reason of the hospital services and supplies. I will pay JMC all charges not paid by payers, which are not subject to a contractual write off. I will authorize JMC to complete any forms necessary to secure payment from payers including but not limited to the filing of an appeal of an ERISA claim. I authorize JMC to endorse any and all checks; drafts or other instruments payable to me for the hospital services and supplies as though I had signed said check, draft or instrument. The undersigned does herewith authorize and instruct all payors, healthcare providers, third party administrators and utilization review companies to release any and all information relating to the patient to JMC regarding payment, treatment and operations.

III. **AGREEMENT TO PAY CHARGES**: I agree on behalf of myself, as patient or guarantor, to pay JMC'S bill in full and to not contest JMC'S charges so long as they are based upon JMC'S current charge listings at the time of service. I also agree that all charges connected with the hospital services and supplies that are not covered by any payer or not subject to any contractual limitation between payor and hospital only are due and payable at the time of discharge or discontinuation of treatment. All other charges will be due upon demand. I agree to pay all attorneys fees, including appellate attorney's fees, court costs and/or collection agency fees associated with the collection process.

IV. **PATIENT INFORMATION DISCLOSURE FOR TREATMENT, OPERATIONS AND PAYMENT**: The undersigned, as the patient or as the guardian or authorized representative of the patient, authorizes JMC to release any and all information regarding the hospital services and supplies including but not limited to copies of medical records, for the purpose of treatment, operations or payment to any payor or other entity or person deemed necessary by JMC. This includes authorization to release information pertaining to psychiatric and/or psychological care (but not psychotherapy notes), alcohol and/or substance abuse and serologic test results including HIV.

V. **MEDICARE AND MEDICAID BENEFITS**: I certify that the information given by me in applying for payment under Medicare is correct (including the answers given by me in response to the questions of the Medicare Secondary Payer (MSP) questionnaire). I request payment of authorized Medical benefits on my behalf for services furnished to me by or in Jupiter Medical Center, including physician services. I authorize any holder of medical and other information about me to release to Medicare and it's agents my information needed to determine these benefits or benefits for related services.

VI. **RELEASE OF LIABILITY AND RESPONSIBILITY FOR PERSONAL VALUABLES**: I understand that I am responsible for all articles and personal property (money, documents, radios, jewelry, dentures, eyeglasses, hearing aids, etc.) and/or clothing which I retain in my possession (on my person or in my room) and for any other articles and/or clothing which may be brought to me while I am a patient in JMC. I hereby release JMC, physician(s) and employees from any claim for loss, damage to or complete destruction of such property, which is not deposited with the hospital for safekeeping in the hospital safe.

VII. **NOTICE OF PRIVACY PRACTICES**: I hereby acknowledge that I have received a copy of the " Notice of Privacy Practices"

VIII. **INDEPENDENT CONTRACTOR**: I acknowledge that the physicians operating and practicing in this hospital are not agents or employees of the hospital. These physicians include but are not limited to the following groups of physicians: Emergency Physicians, Anesthesiologists, Pathologists, Radiologists, Staff and/or Contract Physicians.

IX. **STUDENT HEALTH CARE PROVIDERS:** I understand that I have the right to refuse to have a student health care provider such as a student nurse, respiratory therapist, and pharmacy intern or radiology technology student participating in my care. I understand that by signing this form I am consenting to the supervised care rendered by such health care providers.

X. **DIAGNOSTIC PHOTOGRAPHY AUTHORIZATION:** I authorize radiographic films, x-rays, mammograms and other diagnostic films including still, movie or television photography to be taken of me during my hospital stay and consent to the use of such films for medical, scientific or educational purposes.

XI. A fax and/or photostatic copy of this document shall be considered as effective and valid as the original.

XII. **WORKERS COMPENSATION:** According to Florida Statute section 440.105(7): "Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s.817.234."

XIII. **ADVANCE DIRECTIVE QUESTIONS**

1. Do you have an Advance Directive ☐ yes ☐ no ☐ Unable to respond
2. If yes, is it on file ☐ yes ☐ no. If no, copy requested ☐ yes ☐ no
3. If no Advance Directive, copy given ☐ yes ☐ declined

XIV. **Tobacco-Free Environment:** I understand that Jupiter Medical Center is a tobacco-free environment and that I may not use tobacco products on hospital premises or adjacent property.

ACKNOWLEDGEMENT

The undersigned certifies that he/she has read and understood the foregoing and agrees to its terms:

DATE _____ PATIENT _____ PARENT OR LEGAL GUARDIAN (if patient is a minor) _____

RELATIONSHIP _____ GUARANTOR _____ WITNESS _____