

CONSENT FOR TREATMENT AND HOSPITAL CARE

I am presenting myself for admission to the hospital and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment by authorized agents and employees of the hospital, and by its medical staff, or their designees, as may in their professional judgment be deemed necessary or beneficial.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition.

II. CONTRACT FOR SERVICES AND ASSIGNMENT OF BENEFITS

In consideration of The Fauquier Hospital, Inc. providing the patient named below with medical services, we the undersigned patient and sureties and co-signers for the patient agree as follows:

- A. In connection with third party (insurance, etc.) payment:
 - 1. To authorize the hospital and attending physician(s) to release information acquired in the course of the examination and treatment in connection with this hospital stay for the purpose of insurance, Medicare, and/or other benefit payments.
 - 2. To further authorize payment directly to the hospital and physician(s) accepting this assignment of all hospitalization and medical benefits applicable and otherwise payable to the patient but not to exceed the reasonable and customary charge for these services rendered by said hospital and physician(s).
 - 3. That we hereby certify that the information given by us in applying for insurance payment is correct, and request that said payment of authorized benefits be made on the patient's behalf.
 - 4. To authorize the hospital to act in the patient's behalf as attorney in fact in (1) the collection of benefits from any reasonable third party through whatever means may be deemed necessary; and (2) in the endorsement of benefit checks made payable to me and/or hospital.
- B. To guarantee payment of all charges of the patient whether or not an extension of time is granted for the payment of these charges or the hospital accepts a note for the payment of these charges from either the patient or any third person or party.
- C. That payment for these services is due on the date of the patient's discharge.
- D. To pay interest at the rate of 1.5% per month on any balances remaining after 120 days from discharge, with said interest to commence on the date of discharge.
- E. To pay all expenses incurred in collecting this account including reasonable attorney's fees and collection fees if this account is turned over to an attorney or collection agency for collection.
- F. In relation to other matters, The Fauquier Hospital is hereby released from any responsibility for valuables, money, personal or other possessions which are not deposited with the Hospital at the time of admission. This includes any such articles or money which may be brought in to the patient after admission. The Hospital assumes NO responsibility for the safety of dentures or eyeglasses, as these must be available for the patient's daily use. The Hospital reserves the right to dispose certain personal effects if they are not claimed by the owner within one month of discharge.

III. AIDS AND HEPATITIS TESTING

I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the health care provider it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia law, (Section 32.1 - 45.1 et. seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health providers are deemed to consent to tests and the release of the results to me should I be similarly exposed.

Patient

Witness

Surety and Co-Signer/Responsible Party

Surety and Co-Signer/Responsible Party

Fauquier Hospital's Notice of Privacy Practices describes how medical information about you may be used and disclosed. It also explains how you can get access to this information, as well as whom to contact if you feel your privacy rights have been violated.

Fauquier Hospital's HIPAA Notice of Privacy Practices is available to you in its entirety in hard copy or on our web site www.Fauquierhospital.org.

I, _____, acknowledge that I have been offered Fauquier Hospital's Notice of Privacy Practices.

The Hospital staff will complete the section below

Name _____ MR# _____ DOS _____

Account # _____