FCMH FRANKLIN COUNTY MEMORIAL HOSPITAL
& RURAL HEALTH CLINIC
Caring for those you care about
1406 Q Street Franklin, NE 68939

CONSENT FORM

[X] CONSENT FOR TREATMENT
I consent to admission or treatment within Franklin County Memorial Hospital (FCMH) and Rural Health Clinics. My care is under the supervision of my attending physician and/or treating physician and I permit the doctor(s), employees and all other persons caring for me to treat me in ways they judge beneficial to me while I undergo treatment at FCMH. I understand that this care may include examinations, tests, medical/surgical treatment, interactive telemedicine and anesthesia. No guarantees have been made to me about the outcome of this care. I understand some of the physicians providing care for me may not be employees or agents of FCMH.

[X] PATIENT RIGHTS
I have been informed of my rights as a patient and whom to contact to file a grievance.

[X] RELEASE OF HEALTH INFORMATION
I agree that my health records can be shared with appropriate personal at FCMH, Rural Health Clinics and the members of the Nebraska Health Information Initiative (NeHII) that it participates in who need to know about my health treatment, including my primary care physician. This includes sharing all my past and present health records from places like the Emergency Room, Same Day Surgery, Community Clinic, Inpatient, Outpatient Lab, and X-Ray. I agree that my health records can be shared with my insurance company, workers' compensation carrier, and employer's claim administration. I agree that my health records, including video transmission can be shared with Medicare or Medical Assistance, hospital or medical services company and with any other authorized person, company or government agency. I agree that FCMH may disclose Protected Health Information (PHI) about me for treatment, payment and health care operations as described in the Notice of Privacy Practices.

[X] ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT
I authorize payment of health insurance benefits whether commercial insurance, HMO, Medical Assistance or Medicare, directly to entities of Franklin County Memorial Hospital, not to exceed the balance due for regular charges for this period or hospitalization or treatment. I agree to pay any outstanding balance on this account, any attorney's fees, collection expenses, and interest at the legal rate, should this account become delinquent.

[X] PERSONAL VALUABLES
Any personal property brought onto the premises of FCMH is the responsibility of the patient. Neither Franklin County Memorial Hospital nor any of the entities managed by Franklin County Memorial Hospital shall be liable for the loss or damage to any patient's personal property.

[X] ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE
I have been presented with a copy of the **Notice of Privacy Practices** detailing how my medical/health information may be used and disclosed as permitted under federal and state law.

[X] ADVANCE DIRECTIVES
Information in regard to advance directives has been made available to me.
I do have an advance directive; I do not have an advance directive; or A copy is being/has been provided

[X] SELF-PAY ACKNOWLEDGEMENT
I agree to pay the entities of FCMH or physician(s) the balance owed within 10 days after receipt of the first billing. I agree to pay any outstanding balance on this account and any attorney's fees, collection expenses, and interest at the legal rate should this account become delinquent.

[X] MEDICAL ASSISTANCE PROGRAM (MA) – STATEMENT OF RESPONSIBILITY
In consideration of being admitted as a patient under the MA Program, or in continued hospitalization after admission upon subsequent application for assistance under the MA Program, and for all hospital services to be rendered to the patient during such a period of hospitalization, I/we agree to pay for all hospital services rendered which are not covered by the MA Program.

[X] MEDICARE STATEMENT OF RESPONSIBILITY
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 of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.
I certify that I have read the above information and agree to the terms and conditions therein.

[X] NOTICE OF STAFFING PATTERN
FCMH **DOES NOT** have a physician in the hospital 24 hours a day / seven (7) days a week. You are informed that our hospital utilizes Nurse Practitioners and Physician Assistants as well as Physicians for coverage. They are scheduled on-call and one of the professionals on call will respond within 30 minutes of being called to the hospital by on-duty staff.

[X] PRESCRIPTION MEDICATION
I authorize FCMH and Rural Health Clinic staff to access and review my prescription medication history.

(•) Accept ( ) Deny

Patient Signature ______________________ Witness Signature ______________________ Date ______________