CULLMAN
REGIONAL

Patient #: _____ Room #: _____ MR #: _____

Patient Name: _____

DOB: _____ Age: ____ Sex: __ Date: _____

CONDITIONS OF ADMISSION, PRIVACY NOTICE, PHOTO ID AND FINANCIAL RESPONSIBILITY

CONSENT FOR HOSPITAL SERVICES: Consent is given to Cullman Regional, Cullman Anesthesiology Consultants, Birmingham Radiology Group, Pegasus Emergency Group, Cunningham Pathology Associates, and Cullman EMS, its contractor and its employees to provide hospital services and administer physician orders. Certain procedures may require separate consents. Physicians are responsible for explaining medical or surgical procedures. The undersigned authorizes observers to be present during treatment / surgery for purposes of medical training and education. Physicians are responsible for explaining medical or surgical procedures and patients may be called following their procedure for quality and continium of care.

PERSONAL VALUABLES: **Cullman Regional is not responsible for money, jewelry, dentures, hearing aids, eye glasses, watches, credit cards, and such other items which are not deposited in the hospital safe.**

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorized Cullman Regional and any physician rendering service, for example, Cullman Anesthesiology Consultants, Birmingham Radiology Group, Pegasus Emergency Group, and Cunningham Pathology Associates, and Cullman EMS to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include medical records. The information may be released to third-party payors, including the third party payor's agent and / or representative, or anyone responsible for payment of hospital and / physician charges.

ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payment of benefits (including insurance benefits, otherwise payable with respect to patient) to Cullman Regional, Cullman Anethesiology Consultants, Birmingham Radiology Group, Pegasus Emergency Group, Cunningham Pathology Associates, and Cullman EMS. The undersigned agrees to assist in process claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given to 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 the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Cullman Regional, Cullman Anesthesiology Consultants, Birmingham Radiology Group, Pegasus Emergency Group, Cunningham Pathology Associates, and Cullman EMS, or any physician rendering service during my treatment.

PHYSICIANS: Physician, including without limitation, Cullman Anesthesiology Consultants, Birmingham Radiology Group, Pegasus Emergency Group, and Cunningham Pathology Associates, render services in our facilities. They are not employees or agents of Cullman Regional.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for hospital services, accommodations and physician services rendered to the patient and is hereby obligated to pay the account of the hospital. It is understood that in the event of obstetrics care the undersigned is obligated to pay the hosptial account for mother and infant(s). It is understood and agreed that Cullman Regional charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable cost of collection including attorney fees, colelction agency fees, and / or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all hosptial charges not paid in full to the hosptial by the third-party payor. Cullman Regional accepts cash, MasterCard, Visa, Discover Card, and American Express as forms of payment.

The undersigned is aware that in some cases the patient's hospital bill may not be covered in full by the insurance company. The undersigned is aware of the fact the patient / guarantor is responsible for any balance insurance does not pay. This balance due may include provision set by your insurance company such as co-payments, deductibles, and "usual and customary" allowances. Co-payments and deductibles are due upon admission and be paid prior to discharge. If no insurance is provided, the undersigned acknowledges that the hospital may utilize a third party vendor(s) whose duty is to identify insurance or government sources that may pay for the services rendered. If you have insurance and do not want us to submit a claim to your insurance, you must notify us within 3 days of service.

EXPRESS PERMISSION TO CONTACT PATIENT OR UNDERSIGNED RESPONSIBLE PARTY BY CELL PHONE AND/OR EMAIL: The undersigned agrees, in order for Cullman Regional to service the account of the undersigned or to collect monies owed by the undersigned, Cullman Regional and/or its agents may contact the following telephone number, _____ , which could result in charges to me. Cullman Regional may also contact the undersigned by sending text messages to such number or emails to the following email address, _____ . Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. The undersigned has read this disclosure and agrees that Cullman Regional, its employees, and/or agents may contact the undersigned as described for the purposes set forth herein.

IDENTIFICATION AUTHORIZATION: It is now required to have photo identification, in the event you do not have a proper photo ID, we will be taking a photograph for our records. I do hereby authorize Cullman Regional to photograph me or my relative for whom I am responsible. I understand that the photographs are used to assure quality of patient care for internal purposes only. It will be kept in my Medical Record File and / or Electronic Medical Record at Cullman Regional and will maintain confidential. However, I will not hold Cullman Regional responsible, should my photo be inadvertently released.

Please understand that Cullman Regional may need to disclose certain information about you to federal or local officals for tracking purposes. We are required to report certain diseases or conditions to organizations such as the Alabam Department of Public Health or the Center for Disease Control and Prevention. This list includes but is not limited to: HIV, Tuberculosis, Viral Meningitis, and Hepatitis A, B, and C.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT.
I HAVE RECEIVED THE PRIVACY NOTICE.

_____ **Date:** _____

Guarantor (Agreement to pay)

Witness: _____ **Date:** _____