ROUTINE MEDICAL CONSENT:

I hereby request and consent to hospital and medical care for the patient identified on this record, and the patient's newborn child in maternity cases, including all examinations, test, photographs, and other procedures which my physicians and their assistants or hospital personnel deem necessary and appropriate. Any tissue removed may be disposed of in the Complete Rural Medicine customary manner. I acknowledge that no guarantees have been made as to the results of such clinic and medical care.

ADVANCE DIRECTIVES:

I have been informed of the right of all patients to provide the Clinic with an advance directive concerning Clinic and medical treatment in the event that the patient is later unable to make decisions to consent to or refuse recommended treatment.

AUTHORIZATION:

By signing this form, I also agree to all of the terms and conditions described below.

1. ASSIGNMENT OF BENEFITS TO HOSPITAL AND PHYSICIANS

I hereby assign to Complete Rural Medicine, LLC, for services provided by the this medical clinic and its employees or others working under contract or arrangement with Complete Rural Medicine, LLC, all coverage or other benefits available under any government program, any insurance policy or plan, any workers' compensation claim and any other benefit program, and I direct that all benefits be paid directly to Complete Rural Medicine, LLC, 515 2nd street, Friend, NE 68359.
I hereby assign to medical providers providing services to me at Complete Rural Medicine, who accept such assignment and bill directly for their services, all coverage and benefits available for the services of such physicians and their employees, and I direct that all benefits be paid directly to such physicians at the addresses they specify in their billing.

I agree that Complete Rural Medicine, LLC and the medical providers may directly receive benefit payments and discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the patient or the undersigned. These assignments may not be revoked as to the services provided during this hospitalization.

2. FINANCIAL AGREEMENT

I agree to promptly and fully pay all charges for services and supplied provided by Complete Rural Medicine, LLC, physicians/medical providers, and others providing services in accordance with their regular rates and terms. Except to the extent otherwise provided in the MEDICARE section below. I hereby personally obligate the patient and also personally obligate myself, if signing as the spouse of the patient or as parent of a minor patient, for payment of all such charges at the regular rates to the extent not covered by insurance and agree to pay any charges which, for any reason, are not promptly paid by insurance.
I understand that it is my responsibility to obtain any prior approvals required by my insurer, and to take all other steps to qualify for insurance coverage. Any personal attempts to collect payment from other sources shall not delay financial obligation to Complete Rural Medicine, LLC.

3. RELEASE OF INFORMATION

I authorize release and disclosure of all or any part of the patient's hospital or medical record to any person or entity (or representative thereof) who may be responsible to pay for any portion of the charges incurred. These payers include, but are not limited to, any private insurer, government program, workers' compensation payer, employer or responsible family member.

I further authorize release of pertinent medical information to any physicians or health care facility who may require such records in connection with the patient's continued current or subsequent healthcare.

A photocopy of this release shall be considered valid.

No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release.

This release may not be revoked as to any records relating to services provided during this hospitalization.

4. INDEPENDENT PROFESSIONAL CARE

I understand that the physicians and certain other practitioners providing services to the patient are independent contractors and are not employees or agents of Complete Rural Medicine, LLC and that Complete Rural Medicine, LLC is not responsible for the acts or omissions of such persons.
I understand that if I desire private nursing or other health care services beyond those services normally provided at Complete Rural Medicine, LLC, I will be responsible for arranging for such services. I must clear any private health care arrangements through Complete Rural Medicine, LLC. Complete Rural Medicine, LLC will not be responsible for the acts or omissions of private health care providers.

5. CONTINUING OUTPATIENT CARE

In a few cases, proper treatment of a medical condition requires continuing treatment or diagnosis over a course of repeated outpatient visits. In such cases, the request consent and agreements herein shall apply to all repeat visits for the same condition.

6. PERSONAL VALUABLES

Complete Rural Medicine, LLC will not be responsible for loss or damage of any personal property, money or valuables which that may be left in patient's car whether locked or unlocked. Complete Rural Medicine, LLC is not responsible for loss or damage of personal property, money or valuables in the clinic. I understand that such property is my responsibility.

7. NO MD/DO ON SITE 24/7

MEDICARE PATIENTS ONLY

8. CERTIFICATION AND FINANCIAL AGREEMENT

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 Medicare and its agents any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician service to the physician or organization furnishing the services and authorize such physician or organization to submit a claim to Medicare for payment. I understand that I am responsible for any uncovered charges.

I HEREBY CERTIFY THAT I HAVE READ, I UNDERSTAND AND I AGREE TO THE INFORMATION SET FORTH ABOVE, AND THAT IF I AM NOT THE PATIENT, I AM DULY AUTHORIZED TO SIGN FOR THE PATIENT.

_____ _____
Date Time Patient's Signature

_____ _____
Witness to Signature Patient's Printed Name

_____
Signature of Person with Authority to Consent

_____ _____
Second Witness Signature for a Phone Consent Relationship to Patient