GLEN ROSE MEDICAL CENTER

1021 HOLDEN ST
GLEN ROSE, TX 76043
254-897-2215

AUTHORIZATION, CONSENT AND AGREEMENTS

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient, do hereby consent to and authorize diagnostic and therapeutic treatment considered necessary or advised in the judgment of the physician on duty. I understand that no guarantee of assurance has been made as to the results that may be obtained.

CONSENT FOR POST EMPLOYEE EXPOSURE TESTING: For the protection of our patients and employees, it is the policy of Glen Rose Medical Center Employee Health Services to request consent from source patients whenever possible to perform post exposure lab testing. By signing below, I consent to allow GRMC to perform basic testing to determine presence of Hepatitis and HIV should an employee or affiliated personnel encounter potential blood or body fluid exposure.

FINANCIAL AGREEMENTS: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay all reasonable attorney's fees and collection expenses.

ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies and government payers to pay directly to Glen Rose Medical Center, physicians involved in my/(the patient's) treatment and care, and any ancillary providers; any benefits and fees under my insurance policy/policies or government program of which I/(or the patient is an enrollee or beneficiary). I further authorize Glen Rose Medical Center and any ancillary providers to appeal any denial or partial denial of benefits on my/(the patient's) behalf. I understand that this order does not relieve me of my obligation to pay the account. In addition, any balance that is not covered or paid by the insurance company is my responsibility.

PERSONAL VALUABLES: It is understood and agreed that the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs or garments and the hospital shall not be liable for loss of damage to any other personal property.

ANCILLARY BILLING: In addition to your bill from the hospital, you may receive a bill from the Surgeon, Anesthesiologist, Pathologist and Radiologist for the professional services.

RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize Glen Rose Medical Center, their affiliates or their agents, to release any medical information in connection with the services rendered for determination of benefits, or for collection and said benefits from my health insurance carrier(s) and/or other parties responsible for payment.

CONFIDENTIALITY: I grant permission to Glen Rose Medical Center to acknowledge I am a patient in their facility. I wish to receive visitors. _______ Yes, _______ No.

ACKNOWLEDGMENT OF RECEIPT: I have received Glen Rose Medical Center's Notice of *"Privacy Policies and Practices."*

I HAVE READ THE AUTHORIZATION, CONSENT AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. I ACKNOWLEDGE THAT I HAVE RECEIVED COPY OF THE ABOVE STATED DOCUMENTS BY MY SIGNATURE BELOW.

______________________________	__________	______________________________
Signature of Patient / Responsible Party / Relationship	Date	Patient's Name
______________________________	__________	______________________________
Witness Signature	Date	Patient Account