MEMORIAL HEALTH SYSTEM

COMMUNITY • HEALTH • EXCELLENCE • LIFE

CONDITIONS OF TREATMENT

LAST NAME	FIRST NAME	MI	BIRTHDATE

PARENT/GUARDIAN (CIRCLE ONE) Y / N

NONDISCRIMINATION STATEMENT

Memorial Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or gender identity and transgender.

LANGUAGE AND HEARING IMPAIRED

ATTENTION: If you speak Spanish or Chinese, or have a disability that impairs your ability to communicate effectively, language assistance services, free of charge, are available to you. Please call 740-374-1436. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 740-374-1436. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務 。請致電 740-374-1436 。

ASSIGNMENT OF INSURANCE AND BENEFIT RIGHTS

In the event the undersigned is entitled to medical benefits, of any type whatsoever, arising out of any policy of insurance which insures patient or any other party liable to patient, the rights and benefits of such policy are hereby assigned to Memorial Health System ("MHS") as the undersigned's duly authorized representative for: i)application on patient's bill and receipt of full payment under the policy; ii)initiation, pursuit, and prosecution of administrative appeal remedies and all other legal and equitable remedies with any said insurers or providers of medical benefits; and iii)obtaining a copy of the insuring agreement, governing plan, summary document, and settlement of information; and iv) obtaining a copy of any necessary medical information from providers. Additionally, this assignment is effective for application where the patient may be eligible for reimbursement for certain medications or devices through the medication or device manufacturer. The undersigned authorizes the use of the signature below on all insurances and/or employee health benefits claims and appeal submissions, and for medication/device manufacturer reimbursement applications. The patient and/or undersigned understand and agree that MHS may or may not pursue any policy of insurance or medication/device manufacturer reimbursement, within its sole discretion resulting in patient and/or undersigned's responsibility for all or some of the charges. A copy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT AND PAYMENT GUARANTEE

The patient and/or undersigned agree that in consideration of the service to be rendered to the patient, they hereby jointly and individually obligate themselves to pay the charges incurred in accordance with

the rates and terms of MHS. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. Additionally, the patient and/or undersigned agree, in order for MHS to collect amounts owed, we may contact you using pre-recorded/artificial voice and electronic messages by: i) telephone, including wireless telephone numbers, ii) text messages, and iii) e-mail, which could result in charges to you.

NON EMPLOYED PRACTITIONERS

The patient and/or undersigned understands that he/she may be referred to and receive services from physicians or other health care practitioners who are not MHS employees or agents. This includes Pathologists and Radiologists or other professionals or suppliers of services. MHS is not responsible for the acts or omissions of these non-employed practitioners who are not directed or controlled by MHS.

CONSENT TO TREAT

I hereby authorize MHS, its employees, agents and representatives to perform general treatment resulting from evaluations connected to office visits. By signing below, I give consent to MHS providers and/or such assistants to provide me with medical treatment on current and future appointments.

PRESCRIPTION HISTORY REQUEST

I hereby authorize MHS to obtain my prescription history electronically.

ELECTRONIC PHOTO FOR REGISTRATION AND IDENTIFICATION

I hereby authorize MHS to obtain and use my electronic photo for MHS registration and identification purposes.

HEALTH INFORMATION EXCHANGE

MHS participates in one or more Health Information Exchanges. Healthcare providers can use these electronic networks to securely provide access to your health records so your providers have an accurate understanding of your health needs. I hereby authorize MHS to allow access to my health information through the Health Information Exchange for treatment and other health care operations. I understand that I may opt-out at any time by notifying the MHS Information Management Services/Medical Records Department.

SERVICE NOTIFICATIONS, SURVEYS AND COLLECTION OF AMOUNTS OWED

The patient and/or undersigned agree, in order for MHS to communicate with you regarding service notifications, surveys and collections of amounts owed, we may contact you using pre-recorded/artificial voice and electronic messages by: (i) telephone, including wireless telephone numbers; (ii) text messages; and (iii) e-mail, which could result in charges to you. You may notify us any time that you do not wish to be contacted in this manner and we will respect your choice.

GOVERNING LAW

This Agreement shall be governed by, and interpreted in accordance with, the internal laws of the State of Ohio. Washington County, Ohio, shall be the sole and exclusive venue for any litigation as between the parties that may be brought under, or arise out of, this Agreement.

AUTHORIZATION TO DISCUSS MEDICAL RECORDS

I authorize MHS to discuss my medical issues with the individual(s) listed below if I am not available. This authorization is in effect until revoked by me.

_____	_____
Name	Relationship
_____	_____
Name	Relationship

THE UNDERSIGNED CERTIFIES THAT HE/SHE: (i) HAS READ THE ABOVE NOTICES; (ii) HAS BEEN OFFERED A COPY OF THIS FORM; (iii) IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT; (iv) ACCEPTS THE ABOVE CONDITIONS OF TREATMENT, AND (v) UNDERSTANDS THIS CONDITIONS OF TREATMENT SHALL BE EFFECTIVE FROM THE DATE BELOW UNTIL A NEW CONDITIONS OF TREATMENT IS SIGNED.

SIGNATURE	DATE
Patient/Parent/Guardian (circle one)	