Good Samaritan

Good Samaritan Hospital and All Affiliates
Vincennes, Indiana

Name: _____ **DOB:** _____ **MRN:** _____

1. **Consent for Care:** I hereby consent to any procedures or treatment that may include, but are not limited to: outpatient or emergency room treatment, X-ray examination, anesthesia administration, medications, nursing care, transportation within the main campus and laboratory procedure and other services as are considered advisable for my health and well-being under the general and special instructions of my physician or surgeon. Such services will incur separate charges. I recognize that radiologists and pathologists are independent contractors and are not employees or agents of the hospital and may submit a separate bill.

2. **Information Release:** I authorize you to release information from or to provide copies of my medical or non-medical records (both current and prior hospitalizations) to Medicare, Medicaid, Commercial Insurances, my employer, third-party payers or reimbursement programs paying benefits

3. **Financial Arrangements:** I hereby agree to the terms and agreements, including but not limited to: I have provided complete and accurate demographic and insurance billing information, allowing Good Samaritan and all affiliates to act as my billing agent for services rendered. The undersigned agrees to assign to Good Samaritan and all affiliates all insurance benefits available for any professional, hospital, and clinic services rendered payable to Good Samaritan and all affiliates. The undersigned agrees to promptly pay any charges, including no show fees, or residual insurance balances (within 30 days) unless other written arrangements have been made. Should my account be placed for outside collections, I agree to pay attorney fees reasonable with all costs and expenses incurred.

4. **Valuables:** I understand that the main campus of the hospital maintains a safe for the safekeeping of money and valuables. Good Samaritan and all affiliates will not be liable for the loss or damage to money, documents, personal items or other articles of unusual value, unless such valuables are deposited with the hospital for safekeeping.

5. **Information Privacy:** We (and our Medical Staff) will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health Information. The terms of the notice may change with time, and we will always post the current notice at our facilities, on our web site and have copies available for distribution. I acknowledge that I have received a copy of the Notice of Privacy Practices. I certify that the information is true and correct to the best of my knowledge and belief.

6. **TCPA Consent:** I/we agree for Good Samaritan and all affiliates to confirm appointments, service our account or to collect any amount I/we owe, Good Samaritan and all affiliates, and any of its agents, may contact me/us by telephone at any telephone number associated with this or any other account held by Good Samaritan and all affiliates, including wireless numbers, which could result in charges to me/us. Good Samaritan and all affiliates and any of its agents, may also contact me/us by sending text messages, e-mails or pages, using any e-mail address I/we provided to Good Samaritan and all affiliates or agents. Methods of contact may include using pre-recorded and/or artificial voice messages and/or use of an automatic dialing device, as applicable.

7. **I acknowledge that I have received:** a copy of the Good Samaritan and all affiliates Patient Rights, Financial Policy, Notice of Privacy Practices. I acknowledge that these are posted and I may receive a copy upon request.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Legal Guardian or Representative **Date**

_____ _____

Facility Witness Signature **Date**