Sleepy Eye Medical Center
400 4th Avenue North West
Sleepy Eye, MN 56085
Phone: (507) 794-3571
Fax: (507) 794-5460

Patient Name (please print): ____________________________________

DOB:

1. CONSENT TO TREATMENT

While I am a patient at Sleepy Eye Medical Center (SEMC) - Hospital and Clinics, I hereby consent to (A) such treatment as necessary; (B) the administration of prescribed medications; (C) the performance of other technical procedures by the physician or nurse practitioner necessary for the diagnosis and treatment of my case; (D) the examination and proper disposition of all tissue removed. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me regarding my care and treatment at SEMC or the results of such care.

2. CONSENT STATEMENT TO PERMIT PAYMENT OF HOSPITAL, CLINIC, AND MEDICAL INSURANCE BENEFITS TO SLEEPY EYE MEDICAL CENTER - HOSPITAL AND CLINICS

I hereby request payment of authorized benefits directly to SEMC for services provided to me by or in SEMC. I consent to release of medical and other information about me for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, and determine benefits. I understand that I am financially responsible to SEMC for any charges not paid by my insurance plan. I understand my signature requests that payment be made directly SEMC and authorizes release of medical information necessary to pay the claim(s). If item 12 &!3 of the HCFA-1500 claim and items 52 & 53 on the UB04 are completed, my signature authorizes releasing of my information to that insurer or agency shown.

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made in my behalf. I assign payment for unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductible and non-covered charges.

3. BILLING AND CREDIT POLICY

As a courtesy, the Business Office will file claims to my insurance company if proper information is provided. All patient accounts will be considered due 30 days upon receipt of the bill. I am financially responsible for charges not covered by my insurance, and any late fees charged. I understand that a service charge may be added to any outstanding balances not paid within 60 days.

Checks returned to SEMC for insufficient funds in my checking account are subject to a service charge of $30.00, in accordance with Minnesota Statue 604.113.

4. ACKNOWLEDGE OF DISCLOSURE

I may request to revoke this consent for use and release of information, by written notice to the Business Office Manager, but my revocation will not apply to information already released.

5. RESPONSIBILITY FOR PERSONAL VALUABLES

I acknowledge and understand that I am responsible for my personal valuables including, but not limited to: dentures, eyeglasses, prostheses, jewelry, money, checkbook, or any other items of sentimental value. I release SEMC from any liability for loss by theft or negligence of mine or any SEMC employee of my personal valuables.

I also understand SEMC may restrict my visitors for legitimate reasons. These reasons may include but are not limited to: infection control issues, visitation may interfere with the care of other patients, visitors who are disruptive, my need or my roommate's need for rest or privacy. Please refer to SEMC Patient Visitations poster or handout for more information/details.

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Signature of patient or guardian   Date

Reason patient is unable to sign: ____

Witness(es): ____