THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Consent for Treatment, Authorization to Release Medical Information, Assignment of Insurance Benefits for In-Network Hospitals and Health Care Provider, and Patient Self Determination Act Checklist

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize University of Mississippi Medical Center (UMMC) or my attending physician or any contractor on behalf of University of Mississippi Medical Center to release or disclose information from my hospital medical record pertaining to this hospitalization and/or episode of care, in accordance with the policies of this hospital, to insurance companies and/or hospital benefits programs as needed to process resulting claims.

IN-NETWORK AUTHORIZATION TO PAY INSURANCE BENEFITS: If the University of Mississippi Medical Center and the health care providers are in-network with my insurance provider, I hereby assign payment directly to University of Mississippi Medical Center and/or to my health care providers, benefits payable to me but not to exceed the hospitals or provider regular charges for this episode of care. I understand that I am financially responsible for all charges that may result from services provided to me which are not covered or paid by my insurance provider, including but not limited to all deductible, co-payment, and co-insurance amounts.

OUT OF NETWORK INSURANCE BENEFITS: If UMMC is not in-network with my insurance provider, I acknowledge that UMMC is not accepting assignment of benefits. I understand that I will be financially responsible for all charges that may result from services provided to me.

FINANCIAL AGREEMENT: For services rendered, I, the undersigned, agree to pay all charges not covered by insurance. I also agree to pay all attorney and/or collection fees necessary for the collection of payment.

MEDICAID PATIENT CERTIFICATION: I certify that I am a recipient of the Medicaid Title XIX program and request that payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the Division of Medicaid any requested information concerning medical, insurance, and financial records related to my hospitalization. I assign the Medicaid benefits payable for services rendered to the physicians or organization furnishing such services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT: 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 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 on my behalf. I assign the benefits payable for services rendered to the physicians or organization furnishing such services.

NOTICE TO BENEFICIARIES OF COINSURANCELIABILITY: When services are provided in hospital departments, the beneficiary will receive a hospital bill and will receive bill(s) from any physician providing professional services. The beneficiary/guarantor will be responsible for coinsurance amounts relating to services billed by the hospital and for coinsurance amounts relating to services billed separately by the physician(s). When services are provided in private physician offices or other non---hospital clinics, the beneficiary is responsible only for coinsurance amounts relating to charges billed by the physicians.

CELL PHONE/PAGER AUTHORIZATION: I agree that UMMC and all of its related entities, agents, servicers, debt collectors, independent contractors ,assigns, and successors (hereinafter "UMMC Enterprise") may call, message, text, or otherwise contact me (hereinafter "communication"), including through the use of dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice message, even if I am charged by my telecommunication provider or other party of the communication. I expressly agree that such communication may be made by UMMC Enterprise to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service for which I am charged for the communication) I have provided previously or may provide in the future in connection with my account. I expressly consent to receiving any such communication. With such consent, I specifically waive any claim I may have against the UMMC Enterprise for making such communications to me, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C § 227.

CONSENT FOR TREATMENT: The undersigned authorizes physicians and University of Mississippi Medical Center to furnish medical and surgical treatment deemed appropriate including intravenous solutions, blood transfusions, local, general, and regional anesthetics, antibiotics or other drugs deemed necessary. I am aware that adverse unforeseen reactions can occur and may even result in death. I authorize the hospital and my physicians to take photographs, video, audio, or other images or recordings of me or parts of my body while under the care of the hospital for use in medical evaluation, performance improvement, education or research. I further understand that my identity will be concealed and my privacy maintained if the material is used for educational purposes.

I hereby authorize The University Hospitals and Health System and its medical staff: to preserve, use or disclose, or share for scientific or teaching purposes, including research; to use in grafts or transplants upon living person(s); or to otherwise dispose of dismembered tissue, blood, saliva, parts and the like.

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge I have been informed of the Patient Rights and Responsibilities and understand that a printed copy is available to me at my request.

RETIREMENT/DESTRUCTION OF X---RAYS: I hereby authorize University of Mississippi Medical Center to follow the usual hospital practice of retiring x---ray films and any other graphic data which may be generated during patient's hospitalization four (4) years after they are generated if a report of the findings is retained for the same period as other hospital records. Further, I hereby release and hold harmless University of Mississippi Medical Center, its officers, staff and employees, from any liability connected with this procedure.

VALUABLES: The undersigned hereby releases the hospital from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other Persons.

PATIENT	**Has the patient executed an Advance Directive?**	**YES**	**NO**
SELF	**Has the Advance Directive information been provided to the patient?**	**YES**	**NO**
DETERMINATION	**Is the Advance Directive in the patient's medical record?**	**YES**	**NO**
ACT	**Do you want to discuss Advanced Health Care Directives with someone?**	**YES**	**NO**

Signature of Patient, Guardian or Representative

Signature of Insured

Date/Time

Date/Time

Description of Representative