BOONE COUNTY HEALTH CENTER
AND MEDICAL CLINICS
723 West Fairview Street
P.O. Box 151
Albion, NE 68620

Patient Name:_____

DOB:_____

MR#:_____

FIN#: _____

PATIENT SERVICE AGREEMENT – CLINICS / OUTPATIENTS

1. MEDICAL CONSENT: I hereby request and consent to medical care for myself and my newborn child in maternity cases, including all examinations and tests. By signing this form, I also agree to all of the terms and conditions described below.

2. GENERAL CONSENT TO HIV TESTING: Testing for HIV (Human Immunodeficiency Virus) may be done if an employee of Boone County Health Center comes in direct contact with a patient's secretions (blood, sputum, etc.). This is what we call an exposure incident. HIV is the virus which causes HIV infections that can eventually lead to Acquired Immunodeficiency Syndrome (AIDS). A person develops AIDs when the immune system becomes so damaged that it can no longer fight off disease and infection. Tests are available to determine the presence of HIV antibodies in the blood. A negative test result shows that HIV antibodies were not found in the blood. It does not mean that a person is free of HIV infection because more time may be needed for the immune system to make antibodies. A positive HIV antibody test indicates a previous exposure to the virus and that you have HIV antibodies in your blood and can infect someone else through sexual contact, sharing needles or syringes, or from mother to baby during pregnancy. The test cannot tell you if you will eventually develop signs of illness related to HIV, or if you do, how serious that illness might be. A provider will inform you of test results and will provide appropriate counseling. In addition, a person seeking an HIV test shall have a right to remain anonymous. A healthcare provider shall confidentially refer such person to a site which provides anonymous testing. I understand the test for the presence of HIV may be performed under this general condition of admission when deemed appropriate by my healthcare provider without signing an additional consent for the specific purpose of HIV testing.
   Please initial for consent for HIV testing in the event of an exposure :_____(Initials)

3. STUDENTS AND TRAINEES: I understand that medical, nursing, and other health care trainees may assist in patient care unless I specifically request otherwise.

4. PHOTOGRAPHS: Photographs may be taken for purposes of identification and treatment without obtaining written authorization or consent.

5. AUTHORIZATION TO ACCESS TREATMENT HISTORY INFORMATION:
   I hereby authorize Boone County Health Center Medical Clinics to access historical prescription drug information. If this authorization is refused, this practice may not be able to prescribe controlled drugs to me. I understand this authorization will remain in effect until it is revoked by me in writing.

6. PAYMENT AGREEMENT: Payment is due upon receipt and becomes delinquent on the 1st day of the following month. Facility reserves the right to assess a delinquency charge calculated daily beginning on the 1st day of the month following the date of the bill, at the rate of 1% per month until payment is received by the facility, on amounts not paid to facility by the due date. Patient shall promptly pay to facility all delinquency charges. Facility reserves the right to assess a fee of $25.00 for any check that is returned to facility. Unless waived in writing by the facility, all payments shall be applied first to delinquency charges and returned check charges, if any. Minimum monthly payment policies will apply.

7. ASSIGNMENT OF BENEFITS: I hereby assign to BCHC, for services provided by BCHC and its employee or others working under contract or arrangement with BCHC, all coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to BCHC. I further assign to and direct payment to all physicians providing services to me at BCHC and billing separately for their services, all coverage and benefits available for the services of such physicians and their employees. I agree that the hospital and the physician may directly receive benefit payments and discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payment or other sources may be applied to any other account owed by me or the undersigned. The benefits assigned include, but are not limited to, all benefits for all medical and hospitalization insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid, and CHAMPUS, benefits payable to alternative delivery systems such as HMOs and PPOs or arising from worker's compensation or occupation disease claims; and proceeds to which I am, or my estate is , entitled because of any judgment, settlement, or other claim or cause of action for damages against any person or organization if I was or am injured. This assignment may not be revoked as to services provided during this hospitalization or course of diagnosis and treatment.

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8. NOTICE OF PRIVACY PRACTICES: I was given the BCHC Notice of Privacy Practices (*Patient or responsible party, are asked to **initial** one line below*)
   _____ during this hospital admission/hospital outpatient visit **OR**
   _____ during a previous BCHC encounter **OR**
   _____ I refuse the Notice of Privacy Practice
   I certify that I have read or had read to me the contents of this form. I understand and voluntarily accept its terms. I have had the opportunity to ask questions and any questions I asked have been answered in a satisfactory manner. If I am signing for someone else, I represent that I have legal authority to do so.

9. FINANCIAL AGREEMENT: I agree to promptly and fully pay all charges for services and supplies provided by the hospital, physicians, and other providing services in accordance with their regular rates and terms. I hereby personally obligate the patient, and also personally obligate myself if signing as the patient, the spouse of the patient, or the parent of a minor patient, for payment of all such charges at the regular rates to the extent not covered by insurance, and agree to pay any charges which, for any reason, are not promptly paid by insurance. I understand that it is my responsibility to obtain any prior approvals required by insurer, and to take all other steps to qualify for insurance coverage; I will determine whether my insurer requires pre-certification before I receive hospital services. No extension or forbearance, no attempt to obtain payment from the insurance or their sources, and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligation hereunder. I grant consent for any phone numbers listed in my file (including cell phones) to be used as needed in an effort to collect this debt. By providing my phone number(s) to **Boone County Health Center and Medical Clinics** at any time during our business relationship, I agree that **Boone County Health Center and Medical Clinics**, its affiliates and agents, has Expressed Written Consent to contact me at these numbers for account related reasons. I also agree to being contacted via text messages, automatic dialer calls, via live operator and/or pre-recorded messages. I agree to be contacted by any or all of these channels whether or not the phone number(s) I provide is a home phone, work phone, message phone, or any type of mobile/wireless phone or device. If I choose to provide an email address, I also agree to receive emails for account related reasons.

10. **MEDICARE PATIENTS ONLY**-ASSIGNMENT AND CERTIFICATION: I request payment of authorized Medicare benefits on my behalf for any services furnished me by or in BCHC and assign payment to BCHC. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits for related services. I certify that information I have provided to BCHC is true, accurate and complete.

11. **MEDIGAP PATIENTS ONLY**-ASSIGNMENT OF MEDIGAP BENEFITS: I authorize payment of mandated Medigap benefits to BCHC for any services furnished by it to me. I authorize release of any medical or other information necessary to process such claims. Until revoked, this statement applies to all occasions of service.

_____ _____
Signature of Patient or Legal Representative Date and Time

_____
Relationship if other than Patient

_____ _____
Signature of Witness Date and Time

GUARANTOR AGREEMENT: The undersigned, who is a person other than the patient, patient's spouse, or patient's parent, individually agrees to be personally responsible for the financial obligations set forth above, and guarantees payment of this account.

_____ _____
Signature of Guarantor Date and Time