KIRBY MEDICAL GROUP

CONSENT FOR TREATMENT

I authorize and permit the staff of the Kirby Medical Center to employ such established treatment, therapy, or emergency care as may be deemed professionally necessary or advisable, including (1) diagnostic procedures, which may include blood tests for Hepatitis-B virus antigen and core antibody, ALT (liver function), HIV antibody (AIDS virus), RPR (Syphilis screen) and X-ray examinations, (2) surgical and medical treatment and, (3) blood transfusions. I permit the Emergency room doctors, my doctor, the Hospital and its employees, and all other persons caring for me to treat me in ways judged beneficial to me.

DISCLOSURE STATEMENT

You, the undersigned are about to sign a FINANCIAL AGREEMENT, obligating yourself to pay all Hospital charges.

Before you sign the FINANCIAL AGREEMENT, Kirby Medical Center is required by federal law to supply you with certain information. That information is as follows:

1. There will be NO (0) FINANCE CHARGE assessed and there will be NO (0) ANNUAL PERCENTAGE RATE as result of the terms of the FINANCIAL AGREEMENT.
2. If you fail to make one or more payments when due as specified in the FINANCIAL AGREEMENT, collection cost including court costs and reasonable attorney fees will be assessed against you.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent, relative, or as patient, that in consideration of the services to be rendered to the patient, he/she will himself/herself pay the account of the Hospital for such services in accordance with its regular rates and terms. The undersigned further agrees that if this account becomes delinquent he/she will himself/herself pay all costs of collecting the same including court costs and reasonable attorney fees. No extensions of time or payment shall operate to release the undersigned form this obligation.

ASSIGNMENT OF INSURANCE

I hereby authorize payment directly to the Kirby Medical Center insurance benefits and authorize payment directly to the Hospital thereof but not to exceed the Hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the Hospital for charges not covered by this agreement.

MEDICARE CERTIFICATION

PATIENT'S CERTIFICATIONS "AUTHORIZATION TO RELEASE INFORMATION" AND PAYMENT REQUESTED. I certify that the information given by me in the applying for payment under the Title XVIII of 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.

TEACHING FACILITY

Kirby Medical Center is a teaching facility. I agree that medical students may be involved in my medical care.

RELEASE OF INFORMATION

I AUTHORIZE the Hospital to disclose all or any part of my hospital records to any person or corporation which is or may be liable under a contract to the Hospital or to me or to a family member or employer of mine for all or part of the Hospital's charge, including but not limited to hospital or medical service companies, insurance companies, Medicare, Medicaid, any other federal or state programs, worker's compensation carriers, welfare funds, my employer or any hospital or medical services utilization review program, organization or foundation acting for or in behalf or anyone of them. The Hospital is authorized to release copies of my records to my primary care physician and to all subsequent treatment providers, including but not limited to, home health services and nursing home care.

ACKNOWLEDGEMENT OF RECEIPT OF KIRBY MEDICAL CENTER'S HIPPA NOTICE OF PRIVACY PRACTICE

I hereby acknowledge receipts of Kirby Medical Center Notice of Privacy Policies and understand that it explains when the Hospital may disclose my health information as well as my rights regarding disclosure. I acknowledge that the Notice must be read for a full and proper understanding of Kirby Medical Center's privacy and disclosure policies and that I may contact the Hospital's Privacy Officer, for further explanation at 217-762-2115.

I hereby authorize, permit, certify, agree, and acknowledge as indicated above.

X______________________________ ________________________

Date

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Signature of person authorized to give consent
when patient is a minor, spouse or incompetent to give own consent

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Signature of Witness