ADMISSION CONSENT, PROMISE TO PAY FOR SERVICES, AND ASSIGNMENT OF INSURANCE BENEFITS

Please sign below to confirm that you have read and understand each of the following statements:

1. **CONSENT FOR TREATMENT AND/OR TRANSFER:** I consent to and in the case of an obstetrical patient consent for my newborn(s) any medical or surgical testing, treatment and hospital services deemed medically necessary and performed by a physician, his/her designee, medical staff of Via Christi Hospitals Manhattan, Inc. ("Via Christi") or by Via Christi personnel. I further consent to be transferred to another health care facility if such a transfer is deemed appropriate by the staff physician or other qualified person. I understand that as part of their training, students in health care education may participate In the delivery of my medical care and treatment or be observers while I receive medical care and treatment at Via Christi and that these students will be supervised by instructors and hospital staff.
2. **CONSENT TO BLOOD TESTING:** In the event that a health care worker or emergency response personnel are exposed or are suspected to have been exposed to my blood or body fluids, or in the event that my illness (including any infectious disease) requires such care that a health care worker's or emergency response personnel's exposure to my blood or body fluids is likely, I consent to have Via Christi determine by serological testing whether or not my blood contains contagious agents. I understand that the information obtained from such tests will be disclosed as necessary to adequately protect my own health, the health of my family, and the health of the health care workers or emergency response personnel who may have been or may become involved in my treatment.
3. **RELEASE OF INFORMATION:** I acknowledge and understand that all records concerning my hospitalization remain the property of Via Christi and may be used and disclosed as described in the the Notice of Privacy Practices which I have received. I authorize my insurance carrier to release to Via Christi and physicians providing my care, any information concerning my insurance coverage or benefits, if any, connected with this admission.
4. **DIRECTION TO PAY MEDICAL INSURANCE BENEFITS DIRECTLY TO VIA CHRISTI AND ASSIGNMENT OF INSURANCE BENEFITS:** I certify that the information given by me in applying for payment under the Social Security Act is correct. I authorize release of any Information needed to act on this request and direct that payment of authorization benefits be made on my behalf. I hereby assign payment for the unpaid charge, of the physicians' services for whom Via Christi Is authorized to bill. I understand and agree that I am responsible for any remaining balance not covered by insurance. I promise to pay Via Christi any medical insurance benefits I receive which relate to or arise from hospital care which is the subject of this admission. I hereby assign to Via Christi any and all medical benefits payable from any policy of insurance insuring the patient or person responsible for the patient's care (including, but not limited to, Medicare, Medicaid, Blue Cross & Blue Shield and others) to be paid directly to Via Christi to be applied to the charges for the services rendered. Medicaid Patients Only - Advanced Beneficiary Notice: This constitutes advance notice to you, the beneficiary, that Medicaid requires you to follow the rules of your primary Insurance in processing your claim for payment. If Via Christi has met program requirements, and you fail to follow the rules of your primary insurance, you may be responsible to pay the balance of the charges if your services are later determined not covered by Medicaid.
5. **PROMISE TO PAY FOR SERVICES AND GRANT OF SECURITY INTEREST IN HEALTH CARE INSURANCE RECEIVABLES:** In consideration of the admission, care and treatment provided to the patient, I, whether signing as the patient or the responsible person, agree to pay Via Christi on demand all charges for services rendered in accordance with its regular rates on this date. I understand that Via Christi does not require a third party guarantee as a condition of admission, expedited admission, or continued stay in its facility. By signing this agreement, I affirm that no unwritten oral agreement with Via Christi exists as of the date this agreement is signed. I acknowledge this written agreement may not be contradicted by any prior or contemporaneous oral agreement between Via Christi and myself. Further, should it become necessary to refer the account to an attorney to protect the interests of Via Christi through a

collection proceeding, I agree to pay reasonable costs incurred in such proceeding, including reasonable attorney fees. I understand and acknowledge that such a collection process may result in the exchange of my personal information with the attorney or representative for Via Christi as appropriate to facilitate collection of my balance due and owed by me. In the event pre-certification for treatment is required by any health plan or policy of insurance, I am responsible for obtaining such pre-certification. I agree to be responsible for co-insurance payments, deductibles and/or any remaining balance not covered by insurance. To secure payment of the amounts due to Via Christi for care and treatment provided to the patient, whether signing as the patient or responsible person, hereby grant to Via Christi a security interest in all health care insurance receivables. I acknowledge that I may receive bills for the professional services of physicians who care for me while at Via Christi and that their invoices are separate and apart from Via Christi charges for my care. My signature on this date acknowledges my receipt of the brochure on Billing Practices. I expressly consent that Via Christi, its providers and agents, in order to manage my account and/or collect any amounts owed for services rendered, may place telephone calls to my cellular, residential or other telephone number(s) associated with my account, including those I have provided or which may be available to Via Christi. Further, I acknowledge and expressly consent to Via Christi, its providers and agents, to utilize artificial or pre-recorded voice or auto-dialing technologies for any of these stated purposes or other permissible purposes.

6. **MEDICARE/TRICARE INPATIENTS ONLY:** I have received a copy of "An Important Message" and understand my rights as described in that document.
7. **PERSONAL VALUABLES:** I understand and agree that Via Christi maintains a safe for storage of money and other valuables. I understand and agree that all personal belongings, such as dentures, glasses, hearing aids, clothing, etc. not placed In the safe are solely my responsibility and Via Christi shall not be liable for any resulting loss or damage of such personal property.
8. **CONSENT TO SEARCH:** If the hospital at any time reasonably believes there may be a weapon, explosive device, illegal substance, drug or drug paraphernalia or any alcoholic beverage in my room or with my belongings, I hereby consent to allow the hospital to search my room and belongings for such items. I understand if such items are found, they will be confiscated and disposed of in an appropriate manner, including delivery of any such items to law enforcement authorities.
9. **ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES; DECREASING YOUR RISK OF INFECTION; AND PRIVACY, PAYMENT AND BILLING:** My signature on this date acknowledges my receipt of Patient Rights and Responsibilities; the Notice of Privacy Practices; Decreasing Your Risk of Infection; and Privacy, Payment and Billing Information.
10. **ADVANCED DIRECTIVES:** I have received information regarding advance directives, such as Living Will or Durable Power of Attorney for Healthcare Decisions and understand Via Christi will provide additional information and necessary materials upon request.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, HAS HAD ANY QUESTIONS ABOUT THE ABOVE CONSENT, PROMISE TO PAY, ASSIGNMENT AND SECURITY INTEREST ANSWERED TO HIS/HER SATISFACTION, HAS RECEIVED A COPY OF THIS DOCUMENT, AND IS OTHERWISE DULY AUTHORIZED BY THE PATIENT TO ACCEPT ITS TERMS.

X _____ Date _____

Relationship If other than patient _____ Date _____

Via Christi Representative _____ Date _____ Time _____