Patient Name: _____ DOB: _____

Gage County Medical Clinic
A Beatrice Community Hospital and Health Center Physician Clinic
CONDITIONS OF ADMISSION

1. MEDICAL CONSENT: I hereby give consent to receive medical and healthcare services provided by the physicians, midlevel providers, nurse clinicians, and other healthcare providers of the Gage County Medical Clinic for myself and/or my minor child(ren). Such services may include diagnostic procedures, examination, treatment, or other services rendered under the general and special instructions of the medical provider. I acknowledge that no guarantees have been made to me as the result of treatments or examination in this facility. Patients are encouraged to insist on any additional information needed to make an informed decision to consent or refuse to treatment. This signed consent will be valid and remain in effect unless revoked by the undersigned with a written notice provided to the Gage County Medical Clinic. I permit a copy of this consent to be used in place of the original.

2. GENERAL CONSENT TO HIV TESTING: I understand that a test for the presence of the human immunodeficiency virus ("HIV") may be performed under this general condition of admission when deemed appropriate by my healthcare provider, without my signing an additional consent for the specific purpose of HIV testing. I further acknowledge that I may refuse to have the HIV test performed without my further express permission by signing below. HIV is the virus which causes HIV infection 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, nor if you do, how serious that illness might be. I hereby refuse to consent to HIV testing without further express permission:_____.

(Signature of patient's refusal)

3. RELEASE OF INFORMATION: I understand that the Gage County Medical Clinic may disclose all or any part of the patient's medical record to any person or entity which may be responsible for a portion of the charges incurred. I understand that the Gage County Medical Clinic may release at any time the medical records to any physicians or other healthcare professionals (and their staff) who may require health information in connection with the patient's current or subsequent healthcare for the purposes of continuity of care. I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

4. ASSIGNMENT OF BENEFITS: I hereby assign to Gage County Medical Clinic, for services provided by the Gage County Medical Clinic and its employees, all coverage or other benefits available under any government program, insurance policy or plan, worker's compensation claim, and other benefit program, and I direct that all benefits be paid directly to the Gage County Medical Clinic. I agree that the clinic and the physicians may receive benefits directly, which will discharge the insurer or benefit program to the extent of such payments. Any credit balance resulting from benefit payments or other sources may be applied to any other account owed now or in the future by the patient. 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 by alternative delivery systems, such as HMOs and PPOs or arising from worker's compensation or occupations disease claims; and proceed 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. These assignments and direction may not be revoked as to services already provided. I authorize payment of medical benefits to the Gage County Medical Clinic for services performed.

5. MEDICARE BENEFICIARIES: MEDICARE ONE-TIME AUTHORIZATION: I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Gage County Medical Clinic for any services furnished by the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Name: _____ DOB: _____

6. FINANCIAL ASSISTANCE: Financial assistance is available to **ALL** Gage County Medical Clinic patients. The actual policy and/or application are/is available upon request from the registration staff and billing staff by calling 402-228-3436. The requested form must be completed and returned with the requested documentation within thirty (30) days of receipt.

7. ADVANCE DIRECTIVES: I understand that the Gage County Medical Clinic is required by the Patient Self Determination Act to inquire into and document if I am 19 years of age and older, the existence of my advance directive, if any. I understand that I can request additional information regarding advance directives. I understand it is my responsibility to provide the clinic a copy of a signed Advanced Directive.

8. NOTICE OF PRIVACY PRACTICES: I have been made aware of the Notice of Privacy Practices and been offered a copy of the Gage County Medical Clinic Notice of Privacy Practices. I understand that this notice states how the clinic may use and disclose my Protected Health Information (PHI). I understand that a copy of this notice is available to me upon request and is posted in the clinic for my review during regular business hours.

[ ] Privacy Practice Received Today _____ [ ] Privacy Practice Previously Received _____

9. FINANCIAL AGREEMENT: I agree to pay promptly and fully all charges for services and supplies provided by the Gage County Medical Clinic, physicians and other healthcare providers, in accordance with their regular rates and terms. I hereby personally obligate the patient and myself, if signing as spouse of the patient or as parent of a minor patient or as legal guardian for a minor or other individual, to pay off all such charges. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collecting such charges, shall waive or release these personal financial obligations. I understand that it is my responsibility to obtain any preadmission approval required by my insurer, and to take all other steps to qualify for insurance coverage. If any part of my debt is unpaid after 30 days, I agree that the Patient Accounting representative of Gage County Medical Clinic may, if I am unavailable, leave message(s) on my answering machine or voicemail, information concerning the debt. I have been provided a copy of the Gage County Medical Clinic's Financial Policy.

10. APPOINTMENT REMINDERS: I agree that if I am unavailable, message(s) may be left on my answering machine or voicemail regarding appointment reminders at the clinic.

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 QUESTION AND THE QUESTIONS I HAVE 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.

DATE:_____ SIGNED: _____

(Patient or Legal Representative)

RELATIONSHIP IF OTHER THAN PATIENT: _____