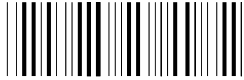

SPARTANBURG
Regional Healthcare System

☐ SMC ☐ SHRC ☐ PMC ☐ UMC ☐ CMC
☐ MGC ____________________________

GENERAL CONSENT TO TREAT/PATIENT AUTHORIZATION ACKNOWLEDGEMENT OF BENEFIT RELEASE

The following are the conditions for services provided by the Spartanburg Regional Health Services District, Inc. (SRHS) for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT

I/we voluntarily consent to medical treatment and diagnostic procedures provided by Spartanburg Regional Health Services District, Inc. and its associated hospitals, physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION

The hospital, practice, and attending physician are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment. This includes information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government, federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and SRHS. I/we understand that such charges are liquidated damages not subject to dispute; that SRHS expects full payment, and that the acceptance of partial payment does not waive SRHS' right to collect full payment even if there is contrary language accompanying partial payment.

I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand SRHS can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected following the SC Setoff Debt Collection Act, I/we shall pay all collection fees and costs, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits. I/we hereby grant permission and consent to SRHS, our assignees, and third party collections agents: (1) to contact me by telephone at any telephone number associated with me, including wireless numbers; (2) to leave answering machine and voicemail messages for me, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by me; (3) to send me text messages or emails using any email address I provide; (4) to use pre-recorded/artificial voice message and/or an automatic dialing device (an 'auto dialer') in connection with any communications made to me or related to my account.

PHOTO/VIDEO/TELEVISING

I/we consent to photographs, televising and/or videotaping for identification, diagnosis and/or treatment purposes. I/we consent to video monitoring in patient care areas for clinical care and safety reasons.

VALUABLES RELEASE FOR HOSPITAL PATIENTS

I/we have been requested to check valuables with the hospital and release the healthcare system of any liability and assume responsibility for any items not deposited to the hospital's care. Any valuables not claimed within thirty (30) days of discharge will become the property of the hospital.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I/we have received a (printed or electronic) copy of the Notice of Privacy Practices (NPP) prior to or at my first visit anywhere within SRHS. I also understand that the NPP is posted in all SRHS locations and may also be accessed at www.spartanburgregional.com. The NPP describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the NPP may be changed from time to time.

INDEPENDENT STATUS OF PHYSICIANS

I understand and agree that some of the practitioners furnishing services to me/the patient, such as radiologists, pathologists, and anesthesiologists may be independent contractors and not employees or agents of the healthcare system. These independent contracted practitioners, not the healthcare system, are responsible for their own acts or omissions. These independent contracted practitioners who render professional services to me/the patient may bill and collect separately from the healthcare system. Furthermore, I/we understand that each healthcare provider may be individually contracted with an HMO or PPO. The contracts could be different from the contracts the healthcare system holds. I/we understand that I/we need to find out if each healthcare provider is a member of my/the patient's insurance provider network.

______________________________	______________________________
Patient Date of Birth	Patient Name
______________________________	______________________________
Date and Time	Signature of Patient/Parent/Guardian/Legally Authorized Representative (Relationship to Patient)

Patient Label