FAIRWAY MEDICAL SURGICAL HOSPITAL

ADMISSION FORM

rev 3/29/12

CONSENT FOR ADMISSION I am entering the hospital for surgical or other treatment, which may include diagnostic procedures. I acknowledge that these treatments and procedures will be those deemed necessary by my attending physician on other medical professionals on the staff at the Hospital. I acknowledge that the treatments and procedures will be performed by physicians, members of the medical staff and employees of the Hospital. I understand and acknowledge that no treatment or procedure at the Hospital can be done without my consent, which consent is based on information given to me or my representative by a medical professional, which details the treatment or procedures to be accomplished, and which is sufficient for me or my representative to give my informed consent to the treatment or procedure. I announce and formally state that I understand all of the above. My signature (or that of my representative) on this form signifies and indicates my consent to my admission to the Hospital with these conditions, those that follow in the paragraphs below, and all of the acknowledgements and understandings listed herein. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

ASSIGNMENT OF INSURANCE BENEFITS I assign the benefits of and authorize payment directly to Fairway Medical those benefits to which I am entitled and which are otherwise payable to me under insurance companies and/or from government agencies for this period of hospitalization. While any insurance or other protection related to the Hospital account may be hereby assigned to and payable directly to the Hospital, the undersigned clearly understands that the obligation to pay the Hospital bill is primarily on the patient and guarantor. While insurance payments received by the Hospital will be applied to the patients account, and any part of the account not paid by the insurance company or not approved as medically necessary by an outside review organization and/or payor is owing and payable by the guarantor.

I certify that the information given by me in applying for payment under Titles XVIII and /or XIX of the Social Security Acts (if applicable) and any other health insurance program is correct. I understand that health care services paid under Medicare and Medicaid programs are subject to review by the Peer Review Organization.

FINANCIAL AGREEMENT The undersigned agrees that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. In case of default of payment, and if this account should be placed with an attorney or collection agency for collection, the individual defaulting shall pay attorney fees, not to exceed twenty-five percent of the amount due and owing, and court cost. An account turned over for collection will also be charged a 15% "collection fee" which will be added on to their bill when the account is given to the agency.

In the event the procedures performed are cosmetic I clearly understand if my doctor performs any additional procedures or the length of surgical time is longer than what was originally quoted there will be additional charges billed to me.

RELEASE OF RESPONSIBILITY FOR VALUABLES I understand that I am fully responsible for all articles of clothing which I retain in my possession as well as any and all other articles and/or clothing. The Hospital is not responsible for loss of or damage to property which is not specially deposited for safekeeping.

CONSENT FOR PHOTOGRAPHY: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Fairway Medical will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Fairway Medical's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

CERTIFICATION OF ADVANCE DIRECTIVE AND INFORMATION RECEIVED

I HAVE EXECUTED AN ADVANCE DIRECTIVE ☐ YES ☐ NO

If yes: ☐ Copy on chart ☐ Copy requested ☐ Copy with patient

I AM INTERESTED IN EXECUTING AN ADVANCE DIRECTIVE ☐ YES ☐ NO

I CERTIFY THAT I HAVE RECEIVED INFORMATION ON EXECUTING AN ADVANCE DIRECTIVE ☐ YES ☐ NO

I CERTIFY THAT I HAVE RECEIVED INFORMATION ON PATIENT RIGHTS ☐ YES ☐ NO

ORGAN DONATION:

ARE YOU AN ORGAN DONOR? ☐ YES ☐ N O

X____ ____

Signature of Patient or Patient Representative Date Witness Date

ACKNOWLEDGMENT OF PATIENTS PRIVACY RIGHTS

I acknowledge that I have been offered a copy of Fairway Medicals Notice of Privacy Practices.

X____ ____

Signature of Patient or Patient Representative Date Witness Date