FLOYD HEALTH SYSTEM

REGISTRATION CONSENT FOR TREATMENT

For purposes of this Registration Consent for Treatment and Guarantor Financial Responsibility Statement, Floyd Health System (FHS) refers to all in-patient and outpatient hospital based services at Floyd Medical Center (Rome, Georgia), Polk Medical Center (Cedartown, Georgia), and Floyd Cherokee Medical Center (Centre, Alabama) as well as all affiliated ambulatory services.

REGISTRATION CONSENT FOR TREATMENT

By signing below as patient or patient's legal representative (collectively "Patient"), Patient hereby authorizes and consents to the rendering of medical and/or surgical care deemed necessary or advisable by Patient's attending physician(s), other practitioner(s) or member(s) of the Floyd Health System (FHS) medical staff consisting of individuals on the medical staff of Floyd Medical Center, Polk Medical Center and/or Floyd Cherokee Medical Center. Patient understands care and treatment may be provided by FHS medical staff, physician employees, medical device manufacturing representatives, medical and allied health students (including Resident-Physicians) and any other health care personnel reasonably required. Patient understands if Patient is to be provided a series of ongoing services based on physicians' orders the Patient consents and authorizes only once for all services provided in the series.

Medical and/or surgical treatment services include but are not limited to, hospital care; examinations (x-ray or otherwise); laboratory procedures; anesthesia (either local or general); medications; surgical procedures; and recording/filming/photographing for internal purposes (i.e. identification, diagnosis, treatment performance improvement, education, safety, security). Patient also consents to the disposal of tissues or parts removed by or in the course of any surgical operation which may be performed on Patient.

Patient understands health care professionals participating in the patient's care will rely on patient's documented medical history as well as information obtained from others having knowledge about the patient; therefore, Patient agrees to provide accurate and complete information about patient's medical history.

In the event of an unintended exposure to patient's blood or body fluids, Patient consents to the drawing and testing of such blood or body fluids for any blood borne infections such as Hepatitis C and HIV/AIDS. Patient consents to the release of such test results to whom it is deemed appropriate by the FHS hospital.

Patient is aware the practice of medicine and surgery is not an exact science and acknowledges no guarantees have been made to Patient as a result of treatments or examinations by any FHS hospital and/or physicians.

Patient understands and acknowledges that some or all health care professionals performing services at FHS hospitals are independent contractors and are not FHS hospital agents or employees. Independent contractors are responsible for their own actions, and FHS shall not be liable for the acts or omissions of any such independent contractors.

Patient or patient's legal representative has read, understands and consents to the terms above and understands this Registration Consent for Treatment will be signed only upon this initial registration and is valid for any treatment at another FHS facility following transfer.

FLOYD HEALTH SYSTEM
Guarantor Financial Responsibility Statement

Assignment of Benefits

In consideration of the services provided at a Floyd Health System facility ("FHS"), patient, as guarantor, or patient's legal representative as guarantor (collectively the "Patient"), irrevocably transfers and assigns to the FHS billing entity all hospital and medical provider benefits payable under patient's health care plan(s), and/or any settlements whether hospital, medical or liability insurance including but not limited to, the proceeds of any settlement or judgment of any third party claim (collectively the "Responsible Payor") as payment for any and all services performed at any FHS entity or affiliate. Patient authorizes and directs any Responsible Payor to pay directly to FHS any benefits due for services provided by any FHS entity or affiliate. If the Responsible Payor will not allow direct payment to the FHS entity or FHS does not accept assignment of the medical benefits, Patient agrees to mail or deliver directly to the FHS entity any payments received from the Responsible Payor for FHS services.

If the admission is for pregnancy, this assignment of benefits (including Medicaid) also applies to any newborn child.

FHS is not under any obligation to appeal or dispute any denial of payment or underpayment from a Responsible Payor; however, if FHS elects to pursue an appeal of any denial or underpayment by the Responsible Payor for the payment of services rendered, Patient authorizes FHS to act on Patient's behalf as necessary.

FHS may use data from third party sources in order to verify demographic information data or evaluate financial options. Patient authorizes the third party sources to provide FHS with all information requested.

Patient acknowledges, upon proof of coverage, FHS has agreed to file claims to Patient's Responsible Payor (including Medicare and Medicaid) as a courtesy and further understands that Patient is financially responsible to any and all FHS entities for any charges not paid under this assignment including charges not paid on a timely basis by the Responsible Payor, any coinsurance amounts, deductibles, charges for services deemed non-covered and settlements or judgments for such items or services (certain exceptions may apply for Medicare and Medicaid beneficiaries).

Patient agrees to provide information regarding the Responsible Payor at the time of service. if such information is not provided by Patient to FHS in a timely manner, the Responsible Payor may deny payment on the claim due to lack of prior notification, authorization, precertification or timely filing and in such cases, Patient agrees to be responsible for the payment of services provided.

FHS reserves the right to bill Patient the charge master rates for provided services for which payment has been denied, disputed or underpaid by the Responsible Payor (exceptions may apply to Medicare and Medicaid Beneficiaries).

FLOYD HEALTH SYSTEM

Authorization to Release Health information

Patient authorizes the release of patient's health information for purposes of payment for medical and/or surgical treatments provided by FHS, as mandated by law, in compliance with Meaningful Use or for healthcare operations. This information may include any records related to the evaluation/treatment of any infectious disease (including HIV/AIDS), drug or alcohol abuse and/or mental illness. Patient waives any privileges with regard to such disclosure. This authorization is valid until such time as all medical bills have been paid.

Communication with Patient

In order for FHS to service patient accounts or to collect liabilities owed, Patient authorizes FHS or any of its affiliates, agents, contractors, assigns and business associates (authorized by FHS to collect, manage or service patient accounts) to call Patient or otherwise communicate with Patient by the use of automatic dialing and announcing devices, pre-recorded forms of voice/message systems, by electronic mail owned or used by Patient and by phone calls or text messages to Patient's cell phone or any other phone number provided by Patient to FHS or any third party associates.

As the individual executing this agreement, I certify that:

- **I am either the patient or an individual legally responsible for the patient and the bill (guarantor);**
- **I have the authority to consent for the provision of health care services to the patient and the assignment of any payor benefits for payment of those services;**
- **I certify the information that has been provided by me is true and accurate;**
- **I have read and understand the assignment of benefits and consents and authorizations given above; and**
- **I understand and agree I am financially responsible for any charges not paid in accordance with this agreement (certain regulations and exceptions apply for Medicare Beneficiaries).**

_____ **(initial)** **In the case of joint custody, the parent who signs the consent will also be considers responsible for payment on the minor's account.**

_____ _____

Signature of Patient Date

_____ _____

Legal Representative/Parent Date Relationship to patient

Verbal Consent _____ Additional Witness _____

Floyd Health System representative _____ Date: _____

A COPY OR ELECTRONIC VERSION OF THIS DOCUMENT MAY BE USED IN THE PLACE OF THE ORIGINAL.

Patient Identification