In consideration of admission to University Hospital:

1. **CONSENT TO TREATMENT**: I hereby authorize the physicians in charge of my care and University Hospital to perform upon me such technical procedures, administer such drugs, and render such medical care as the judgement may indicate as necessary or advisable. This includes the taking of photographs or video for the purpos of documenting care during the course of my treatment. I understand that no guarantee has been made as to the resul that may be obtained. I acknowledge that the physicians who will care for or treat me while in the hospital are n employed by University Community Hospital. I understand that the physicians are independent contractors and w bill me separately for their services.

2. **RELEASE OF INFORMATION:** The Hospital may disclose all or any part of my medical record to any person c corporation which is or may be liable under a contract to the Hospital or to the patient or to the family member or employe of the patient for all or part of the Hospital's charge, including, but not limited to, hospital or medical service companies managed care companies, the Professional Review Organization under contract with Hospital, worker's compensatio carriers, veterans administration, welfare, the patient's employer and for the use by the Hospital for the purposes c marketing their services to me and raising funds for the UCH Foundation. I further authorize any hospital, health car institution, physician or other provider that attended to me previously to furnish to University Hospital a of my medical records including x-ray films and laboratory test results which may be requested. I also authoriz University Hospital to release my medical information and/or copies of my medical record, as may b requested, to any physician, health care facility, ambulance service, home health agency, medical equipment company case management company or Assisted Living Facility (ALF) which provides treatment/service subsequent to m discharge from University Hospital. If permanent hardware or medical devices are used during m Hospitalization, I consent to the release of my Social Security Number to the agency responsible for the registration o these devices as well as the monitoring of the safety of these devices. I understand that this is for my benefit and safet in the event of warnings, recalls, and similar information.

3. **MEDICARE/MEDICAID/PATIENT CERTIFICATION/RELEASE INFORMATION AND PAYMENT REQUEST**: certify that the information given by me in applying for payment under title XVII and/or XIX, of the Social Security Ac is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment o authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician anc for hospital or medical facility services to University Hospital or the organization furnishing the services and authorize such physician or organization to submit a claim to Medicare or Medicaid.

4. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize, request and direct any and all insurance companies to pay directly to University Hospital, Tampa Florida, the amount due me in my pending claims for the hospital benefits under the respective policies. I agree that, should the amount be insufficient to cover the entire hospital expense, I will be responsible for payment of the difference, and that if the nature of my disability or illness or the services provided to me be such that they are not covered by said policy, I will be responsible to the hospital for payment of the entire bill. I understand that I am responsible for any health insurance deductible, co-payments, co-insurance and noncovered services.

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5. **GUARANTEE OF PAYMENT**: For value received, the undersigned each hereby agree to guarantee and promis to pay University Hospital all charges and expenses incurred in the treatment of the named patient, includin those expenses not covered by any insurance policy presently in force. If any action at law or in equity is brought t enforce this agreement, University Hospital shall be entitled to reasonable attorney's fees, court costs, an any other costs of collection endured. I understand that all bills are payable and become due upon presentation. understand the hospital's right to review credit bureau files for financial information and collection of unpaid debts.

6. **NON-HOSPITAL CHARGES**: The hospital charges for performing your tests and for the use of hospital supplie and equipment. You may obtain a detailed itemization of your hospital charges upon request from the Business Offic after discharge. You will also receive a SEPARATE bill for the Emergency Room physician and/or for professiona (physician) interpretation of certain tests (for example, lab and x-ray) performed at UCH. The Hospital participates i many HMO's and PPO's, however, the physicians who provide the service(s) you need **MAY NOT** participate with you plan. Please check with your plan regarding hospital based physician participation in your network.

7. **NOTICE TO PATIENTS:** I acknowledge this NOTICE that I may receive care provided by physicians employed b the Florida Board of Education or University of South Florida Board of Trustees who are faculty members, fellows c residents in their College of Medicine and that their liability, if any, for care provided to me is limited by law.

8. **RELEASE OF VALUABLES:** I hereby acknowledge that security for valuables has been offered and I agree tha University Hospital shall not be held responsible or liable for the loss of any personal property brought o claimed to have been brought into the hospital by the named patient or his/her agent unless such personal property ha been given to the hospital for safe keeping and a receipt for same provided. All personal property given to the hospita for safe keeping will be returned upon request at hospital's convenience.

9. **ACKNOWLEDGMENT:** My signature acknowledges that I have:

a. read and understand each of the preceding sections 1 through 8.
b. received a copy of the patient rights and responsibilities.
c. if pregnant, received a copy of the Florida Birth N.I.C.A. Pamphlet.
d. received a copy of the UCH Notice of Privacy Practices on this visit or a previous visit.
e. received a copy of Important Message from Medicare, if applicable.
f. received information on smoking cessation

Patient unable to sign __________ Reason ______________________________

______________________________ ______________________________

(Patient or Person Authorized to Consent) (Next of Kin Co-Sign)

______________________________ Date ____________, ___ Time: __________

(Print Name if other than Patient)

______________________________ ______________________________

(Relationship to Patient) (Registrar Witness)

GENERAL CONSENT AND FINANCIAL AGREEMENT

University Hospital

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