

CONDITION OF SERVICES

- 1. PHYSICIANS ARE <u>NOT</u> EMPLOYEES OR AGENTS OF THE CENTER. All physician, surgeons, and various allied healthcare professionals furnishing services to the patient, including but not limited to all physicians and other independent practitioners who are consulted or otherwise participate in the care of the patient, are independent contractors with the patient and not employees or agents of the center. The patient is under the care and supervision of his/her attending physicians and it is the responsibility of the center and its nursing staff to carry out the instructions of all physicians. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or center services rendered for the patient under the general and special instructions of the physician.
- 2. FINANCIAL OBLIGATIONS: Notwithstanding paragraph 1, I agree to promptly pay all center bills in accordance with the regular rates and terms of Village Emergency Centers. Should any account be referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law. I understand the center may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt.
- 3. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO THE CENTER: I assign and herby authorize direct payment to the center of all insurance and plan benefits payable for services rendered. I authorize the center and/or center-based physicians to appeal any denial under my appeal rights provision. I agree that the insurance company's or health plan's payment to the center pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to the assignment.
- 4. MEDICARE PAITIENT'S RELEASE OF INFORMATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges of the hospital and physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance. Medicare patients may sign a release and be treated as self-pay patients.
- 5. RELEASE OF INFORMATION: I hereby authorize Village Emergency Centers to release any information necessary to insurance carriers regarding my illness and treatments; process insurance claims generated in the course of examination or treatment; allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. I also authorize a release to my physician and I will notify the facility.
- 6. ACCIDENTAL EXPOSURE OF HEALTHCARE WORKERS: I understand that state law proves and I agree, that if any healthcare worker is exposed to my blood or other bodity fluids to allow Village Emergency Centers to perform tests on my blood or other bodily fluids to determine the presence of any communicable diseases. I understand that the results of tests taken under these circumstances do not become part of my medical record.
- 7. FINANCIAL RESPONSIBILTY AGREEMENT BY PERSON OTHER THEN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE: I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Obligations (Paragraph 2) and Assignment of Insurance or Health Plan Benefits (Paragraph 3).

Date	Time	Financially Responsible Party	Witness



CONDITION OF SERVICES

I confirm that I have read and/or verbalized, understand, and accept the terms of this document, and am the patient, patient's legal representative, or duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date	Time		
Patient/Parent/0	Guardian/Conservator/R	Responsible Party	If other than patient, indicate relationship
Witness		Witness	
cy Centers. I under of my treatment wil Centers. I consent Village Emergency 2. Consent to P	n independently contract estand that medicine and I be what I want it to be. I to all necessary testing Centers to retain and d	d surgery are not an exact so Knowing this and agreein g and treatment while I are dispose of any specimen o	st will order all tests and treatment at Village Emergen- science and that there is no guarantee that the outcome g to this, I request to be a patient at Village Emergency n a patient at Village Emergency Centers. I authorize r tissue taken from the below named patient.
graphs will be mai		he patient's permanent m	edical record. I understand and acknowledge that the
	cknowledge that this ce s of nursing practices. I		are to meet my/the patient's needs in accordance with edge that the center may use cameras or other devices
			am the patient, the patient's legal representative, agent to execute the above and accept its terms.
Date	 Patient/Patient'	's Authorized Signature	
ii other than batic	ent, indicate relationship	o Witness	