FOR RECURRING PATIENT ONLY! This form applies to the patient's course of treatment.

ALL AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT, OR BY THE PATIENT REPRESENTATIVE OR NEAREST AUTHORIZED RELATIVE IN THE CASE OF A MINOR OR WHEN THE PATIENT IS PHYSICALLY OR MENTALLY INCOMPETENT.

1. **NURSING CARE:** The Hospital Authority of Valdosta, Lowndes County, Georgia d/b/a South Georgia Medical Center ("South Georgia Medical Center") provides general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. South Georgia Medical Center shall in no way be responsible for failure to provide a private duty nurse, and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

2a. **IMPORTANT NOTICE: Some or all of the health care professionals performing services in South Georgia Medical Center are independent contractors and are not South Georgia Medical Center agents or employees. Independent contractors are responsible for their own actions and South Georgia Medical Center shall not be liable for the acts or omissions of any such independent contractors. As independent contractors, South Georgia Medical Center does not control the diagnosis and treatment of patients or the exercise of medical judgment by these independent contractors and is not responsible for their acts or omissions. In addition to the South Georgia Medical Center bill, you may receive a separate bill from the independent contractor for services rendered.**

2b. **CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** The undersigned consents to procedures which may include, but are not limited to: emergency treatment and services, laboratory procedures, x-ray examination, diagnostic testing, medical or surgical treatment or procedures, anesthesia, or hospital inpatient and outpatient services rendered the patient under general and special instructions of his/her physician. I consent to being photographed, audio or video recorded for the purposes of identification, safety, medical care and treatment and for the South Georgia Medical Center's internal performance improvement and educational activities. South Georgia Medical Center assumes no responsibility for photographing or other imaging that it did not create (to include cell phones, digital cameras, and other handheld devices). I further understand that South Georgia Medical Center participates in approved health education programs which permit students to observe and participate in patient care. The undersigned agrees to allow supervised student participation related to the delivery of care to his/her care as a part of the student's education.

3. **RELEASE OF INFORMATION:** To the extent necessary to determine liability for payment and to obtain reimbursement, the South Georgia Medical Center may disclose portions of the patient's record, including his/her medical records, **INCLUDING MENTAL HEALTH, DRUG/ALCOHOL ABUSE RECORDS**, to any person, or corporation which is or may be liable, for all or any portion of the South Georgia Medical Center's charge, including but not limited to insurance companies, governmental agencies, health care services plans, or workers compensation carriers. I also agree that if all or any part of such insurance benefits are denied, I and/or the undersigned will be liable for all charges for the delivery of services. Unless you provide notification as stated below, South Georgia Medical Center may disclose your records for treatment, payment or healthcare operations. If you do not want South Georgia Medical Center to disclose portions of your medical record to an individual or corporation that may be liable for payment for your services, **you must pay for the charges in full at the time of the visit** and notify South Georgia Medical Center that you do not want your medical record information disclosed to the third party. **IF YOU DO NOT WANT THE RECORDS SENT TO YOUR INSURANCE COMPANY, PLEASE NOTIFY REGISTRATION and remit payment at the time of the visit.**

4. **HEALTH INFORMATION EXCHANGE:** A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize South Georgia Medical Center to access any of my health information that is available in an HIE, and South Georgia Medical Center will also make my South Georgia Medical Center health information available through HIEs in which it participates unless I opt out. **If I choose to opt out, I must make this request in writing,** by signing a Health Information Exchange (HIE) Notice and Opt Out Form, South Georgia Medical Center will exclude all of my health information from the HIEs in which South Georgia Medical Center participates.

5. **ASSIGNMENT OF BENEFITS:** I authorize payment directly to South Georgia Medical Center of insurance hospital benefits, health benefits and major medical benefits due me for myself or my dependent but not to exceed the South Georgia Medical Center's regular charges for this period of hospitalization or for the delivery of care for myself or any family member and if South Georgia Medical Center has a fee schedule negotiated with my insurance or health plan insurer in accordance with the contractual arrangement and fee schedule documented in the contractual arrangement. I understand that if South Georgia Medical Center does not have a negotiated contracted rate with my benefit plan, I am responsible for payment of the charges that exceed the amounts paid by my benefit plan not to exceed the regular charges for the services received.

   Social Security Medicare (if applicable): I, the undersigned, certify that the information given by me in applying under Title XVIII of the Social Security Act is correct and, if inpatient, I have received from South Georgia Medical Center the Medicare beneficiary notice entitled **"An Important Message From Medicare / Champus"**. I authorize South Georgia Medical Center and my physicians to release to the Social Security Administration or its intermediaries any information needed for processing of this or any other related Medicare claim. I request and assign that payment of all authorized benefits be made to the South Georgia Medical Center and/or Physicians on my behalf. I assign payment for the unpaid charges for certain in-hospital physician services furnished by specialists, and by physicians for whom the South Georgia Medical Center is authorized to bill. I understand that I am personally responsible for any non-covered services, health insurance deductibles, co-payments and co-insurance.

   Medicaid (if applicable): I, the undersigned, certify that I am a recipient of the Medicaid Program, Title XIX, and request that payment of authorized benefits be made on my behalf to South Georgia Medical Center or its assignee. I authorize the South Georgia Medical Center and the Insurance Carrier to make available to the Division of Family Services and the Department of Community Health in my state any requested information concerning medical, insurance and financial records relating to my hospitalization and/or outpatient care. I hereby certify all insurance pertaining to outpatient or inpatient care and treatment, is hereby assigned to the South Georgia Medical Center and/or Physicians, for services provided.

   Commercial Insurance and Assignment: By signing in the space below as **Patient** and/or **Subscriber**, I hereby authorize, request and assign payment directly to those organizations (hospital and physician) who render bills covering this period of treatment, and past and future treatment if related to the incident or condition giving rise to this admission, by all insurance carriers with whom I have coverage or from whom benefits are, or may become, payable to me including settlements or judgments flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me, but shall not exceed the regular charges for this and any other period of treatment and if South Georgia Medical Center has a fee schedule negotiated with my insurance or health plan insurer, payment shall be made in accordance with the contractual arrangement and fee schedule documented in the contractual agreement. I understand that if South Georgia Medical Center does not have a negotiated contracted rate with my benefit plan, I am responsible for payment of the charges that exceed the amounts paid by my benefit plan not to exceed the regular charges for the services received.

   I hereby assign the **Attending Practitioner and any treating provider who is on the medical staff of South Georgia Medical Center** the same authorization to release medical information and to receive insurance benefits as contained in Paragraph 5 herein, when and where applicable to any services rendered by them.

6. **FINANCIAL AGREEMENT**: Each person signing below, whether as patient, spouse, guarantor, or in any other legal capacity (the "undersigned"), agrees that in consideration of the services to be rendered to the patient, such consideration is acknowledged by each of the undersigned as adequate and sufficient, he/she is jointly and severally obligated to pay all charges arising from the admission of the patient. This obligation to pay all charges is unconditional and absolute. You agree that you are responsible to ensure that South Georgia Medical Center receives the accurate and complete information regarding your insurance plan or benefit plan.

   The undersigned agrees to pay all balances due and payable at the time of the patient's discharge from South Georgia Medical Center.

   South Georgia Medical Center may also disclose to any treating provider furnishing services to the patient, information regarding payment by or on behalf of the patient for services the South Georgia Medical Center provided the patient, including South Georgia Medical Center's decision regarding same.

   In the event excess funds remain from my insurance or the insurance or other liable third party(ies) over and above that necessary to pay this account, South Georgia Medical Center is authorized to apply such funds to any account which is owed by myself, my spouse, or legal dependents of myself or spouse at that time.

   Each of the undersigned agrees that South Georgia Medical Center may, with or without notice assign, transfer and convey to any attorney its right, title and interest in and any balance due after the patient's discharge and after a reasonable attempt to collect in accordance with South Georgia Medical Center policies. If suit is filed, the undersigned agrees to pay whatever additional costs, damages, fees, and expenses incurred in pursuing such claim which may be determined as reasonable by the Court. I hereby authorize South Georgia Medical Center to contact me via telephone, including without limitation my cellphone or other numbers that I provide to South Georgia Medical Center for the purposes of seeking payment for my debt obligations to South Georgia Medical Center, including through the use of auto-dialers. I have read and understand Patient Rights and Responsibilities for South Georgia Medical Center.

7. **RELEASE OF RESPONSIBILITY FOR VALUABLES:** I hereby release South Georgia Medical Center from all responsibility relative to the loss or damage to money, and/or valuables and/or property which are taken to the patient's room. I understand that South Georgia Medical Center does not assume responsibility for personal possessions that are not placed in the vault and itemized on the inventory sheet for safekeeping.

8. **PRIVATE ROOM REQUEST:** I understand that I am being assigned a private room ❑ at my request, ❑ at the request of my physician, ❑ no semi private room available.

   Having been shown current private and semi private room rates, I am responsible for any room charge in excess of that covered by my insurance.

   The undersigned certifies that he/she has the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient's legal representative to execute the above and accepts its terms.

9. **NOTICES GIVEN:** I acknowledge receipt of or adequate accessibility to South Georgia Medical Center's **Notice of Privacy Practices** and the **Notice of Patients Rights and Responsibilities**.

Witness _____ Patient (if minor, patient's parent or guardian) _____

Date: _____ Time of Signing: _____ AM/PM Guarantor/Patient: _____

SGMC

- South Georgia Medical Center
- Smith Northview Campus
- Berrien Campus
- Lanier Campus

CONDITIONS OF ADMISSION

PATIENT'S RIGHTS AND RESPONSIBILITIES

This Patient's Rights and Responsibilities handout applies to South Georgia Medical Center ("SGMC"), SGMC Lanier Campus, and SGMC Berrien Campus (collectively referred to as "SGMC"). SGMC respects the rights of each patient, recognizes that each patient is an individual with unique health care needs, respects the need for personal dignity and privacy, and seeks to provide considerate, respectful care focused on individual needs within SGMC's ability, mission, policies and consistent with law and regulations. SGMC will assist you in the exercise of your rights and will inform you of any responsibilities related to the exercise of your rights.

You or your surrogate (as allowed by law, regulations, and SGMC's ability, mission and policy) have the right to . . .

A. receive treatment regardless of disabilities, race, color, creed, gender, national origin, age, culture, language barriers, sexual orientation, gender identity or expression, religion, ethnicity, socioeconomic status, or sources of payment.
B. with your permission, have family or a surrogate decision maker, as allowed by law, to be identified and to be involved in your care.
C. care that respects your psychosocial, spiritual, and personal values, beliefs, preference and cultural values.
D. be free from mental, physical, sexual, and verbal abuse, neglect and exploitation.
E. receive information regarding advance directives upon request and have them honored as allowed by law, regulations and SGMC policy.
F. access, request amendment to and receive an accounting of disclosures of your health information.
G. confidentiality of personal information.
H. a safe, secure, supportive environment which preserves dignity and contributes to a positive self-image.
I. know the names and professional status of your caregivers and to consult with a specialist when medically appropriate.
J. consent or to refuse to consent to photographic, video, electronic, or audio media recording made for purposes *other than* identification, diagnosis, or treatment and to consent or to refuse to consent to any medical or clinical research trials.
K. make informed decisions which includes the right to:
    1. receive information about your health status and to participate in your plan of care;
    2. receive information about any proposed procedures or treatments including any risks, expected or known possible outcomes, reasonable alternative treatment options and any unanticipated outcomes;
    3. request or to refuse treatment, as allowed by law; and
    4. include or to exclude family in care.
L. effective communication which includes communication assistance for your special needs, if any, and assistance in communication with family members or significant others outside of SGMC.
M. an itemized explanation of your bill.
N. be involved in resolving dilemmas about care, treatment and services and to freely voice complaints and to recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services. You have the right to timely resolution of any complaints regarding your care.
O. pain management.
P. a list of protective and advocacy services when requested.
Q. full and equal visitation privileges, unless restricted for medically appropriate circumstances.
R. privacy while receiving care and treatment and during personal hygiene activities, such as toileting, bathing, and dressing.
S. have health care professionals not involved in treatment or examination excluded from the examination or treatment area.
T. retain and use personal clothing, unless doing so is medically or therapeutically contraindicated.
U. keep personal effects in your room, unless doing so interferes with the provision of care or infringes on the rights of others.
V. remain free from restraints or seclusion, except as clinically necessary.
W. have your wishes regarding organ donation documented and honored, within the limits of the law and capabilities of the facility.
X. have access to a telephone and space for private telephone conversations.
Y. have a family member or representative notified upon your admission.
Z. have your physician notified upon your admission.
AA. request and receive a written summary of per service charge rates.
BB. object to a premature discharge and appeal a discharge through the discharge appeals process.
CC. request a room transfer.

You are responsible for . . .

A. **providing information:**
    1. providing caregivers with complete and accurate health information, including information about any perceived risks in your care and unexpected changes.
    2. letting your caregivers know whether you clearly understand the planned treatment and what is expected of you.
B. **asking questions** regarding your care, treatment, and services.
C. **following instructions,** including safety instructions, regarding care, treatment and services and for expressing concerns about your ability to follow your plan of care.
D. **following your treatment plan** and keeping appointments or canceling them in advance.
E. **your actions if you refuse treatment** or do not follow the health care provider's instructions or SGMC's policies.
F. **making sure the financial obligations** of your health care are fulfilled as soon as possible.
G. **following SGMC's rules and regulations** affecting patient care and conduct, which includes no smoking and staying on your assigned unit.
H. **being considerate and respectful** of the rights and property of other patients, visitors, and SGMC staff.

Filing Complaints

Privacy: If you believe that your privacy has been violated and the issue is not resolved to your satisfaction, please contact the respective campus Patient Representative: SGMC/SGMC Outpatient Plaza Patient Representative at 229-259-4415 or 229-259-4414, the SGMC Lanier Campus Patient Representative at 229-482-8400, or the SGMC Berrien Campus Representative at 229-433-8664.
Complaint: Voicing your complaint directly to a caregiver or other SGMC staff member, should, in most instances, resolve the problem promptly without the need for further action or a formal review.
Grievance: Should you wish to file a grievance, please contact the appropriate SGMC Patient Representative and be specific that you are filing a grievance. Please note that you have the right to file a grievance with the State or other regulatory agency without first filing a grievance with SGMC.

Healthcare Facility Regulation Complaint Intake Unit (1-800-878-6442)
Medicare Quality Improvement Organization for the State of Georgia (1-844-455-8708)
The Joint Commission (800-994-6610) or patientsafetyreport@jointcommission.org

Billing: Should you have questions relating to your bill, please contact Patient Financial Services at 229-333-1040. South Georgia Medical Center maintains financial assistance programs for patients that satisfy the financial assistance eligibility requirements. Please contact Patient Financial Services for more information on the financial assistance programs.

SGMC+

- South Georgia Medical Center
- Smith Northview Campus
- Berrien Campus
- Lanier Campus

CONDITIONS OF ADMISSION