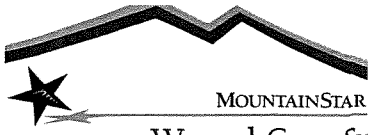

PATIENT REFERRED FROM_____

PRIMARY CARE PHYSICIAN:_____

DATE:_____ SOCIAL SECURITY # _____

DATE OF BIRTH:_____ GENDER: M F MARITAL STATUS: M D S W

LAST NAME: _____FIRST NAME: _____M.I._____

ADDRESS:_____CITY, STATE, ZIP:_____

PHONE: (___)_____ CELL: (____)_____ WORK: (___)_____

PHARMACY_____

EMPLOYER:_____ JOB HELD:_____

ADDRESS: _____ PART TIME FULL TIME

PERSON TO NOTIFY

-NAME:_____PH:_____CELL:_____

ADDRESS:_____
RELATIONSHIP: FA MO SIS BRO DA SO SP FRIEND GRANDPARENT PARTNER OTHER__
IF SPOUSE: DOB:_____ EMPLOYER:_____
RETIRED □ DATE:_____

-NAME:_____PH:_____CELL:_____

ADDRESS:_____
RELATIONSHIP: FA MO SIS BRO DA SO SP FRIEND GRANDPARENT PARTNER OTHER__

ILLNESS/ACCIDENT INFORMATION

DATE OF ILLNESS/ACCIDENT: _____ #_____

WOUND LOCATION: _____ INS. CARD _____ I.D _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ POLICY #: _____

GROUP #: _____ EFFECTIVE DATE: _____ COPAY Y N

INSURANCE UNDER: _____

SECONDARY INSURANCE: _____ POLICY #: _____

GROUP #: _____ EFFECTIVE DATE: _____

INSURANCE UNDER: _____

MOUNTAINSTAR
Lakeview Hospital

Photography Consent

Patient Name: _____

I, _____ consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's health care operations purposes (*e.g.,* quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law.

I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

_____ _____

Patient Name Date

_____ _____

Witness Date

Patient Label

Consent for Outpatient Services

1. Consent to Treatment. I consent to the procedures which may be performed during this outpatient episode of care, including emergency treatment or services and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I further consent to the hospital conducting blood-borne infectious disease testing, including but not limited to testing for hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a physician orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. Financial Agreement. In consideration of the services to be rendered to me, or to the patient for whom I am accepting responsibility, I individually promise to pay the patient's account at the rates stated in the Hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the services provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill my insurance company, but is not obligated to do so. Regardless, I agree that except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I agree to pay any services that are not covered and covered charges not paid in full by my insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with insurance plan requirements. I also agree that if the hospital must initiate collection efforts to recover amounts owed by me, then in addition to amounts incurred for the services rendered I will pay, to the extent permitted by law: (a) any and all costs incurred by hospital in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rule or statutes permit the hospital to recover.

3. Consent to Wireless Telephone Calls. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

4. Consent to Email Usage for Discharge Instructions. If at any time I provide an email address at which I may be contacted, I consent to receiving discharge instructions

at that email address from the hospital. These discharge instructions may include, but not be limited to: post-operative instructions, physician follow-up instructions, dietary information, prescription information.

5. Consent to Photographs, Videotapes, and Audio Recordings. I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's healthcare operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.

6. Release of Information. I permit the hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

7. Assignment of Benefits. In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. If the insurance carrier providing my coverage fails to pay the hospital or hospital-based physicians directly, as they are hereby directed to do, I acknowledge that it is my duty and responsibility to immediately pay any such benefits received by me to the hospital or hospital-based physicians. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all payments for the healthcare rendered, which are paid pursuant to any and all insurance policies and health benefit plans from which I am entitled to services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. I further hereby irrevocably assign and transfer to the hospital and/or hospital based physicians an independent right of recovery against the patient's insurer or health benefit plan, but this assignment shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health plan benefit and the foregoing assignment does not divest me of such right. In no event will the hospital and/or hospital-based physicians retain benefits in

excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer should the hospital or hospital-based physicians elect to collect such payment. In the event the hospital and/or hospital-based physicians elect to exercise its independent, non-exclusive right of recovery against the patient's insurer or health plans. I hereby appoint the hospital and/or hospital based physicians as my authorized representative(s) to pursue, any administrative remedies, claims and/or lawsuits on my behalf and, at the election of the hospital and/or hospital-based physicians, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital and/or hospital-based physicians elect to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital and/or hospital-based physicians to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital and/or hospital-based physicians to bring suit against the third party payer in my name. I agree to pay over to the hospital and/or hospital-based physicians immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital and/or hospital-based physicians (up to the amount of the hospital and/or hospital-based physicians, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital based physicians.

**Hospital-based physicians include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, and Anesthesiologists Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by their companies.*

8. Medicare Patient Certification and Assignment of Benefit. I certify that the information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

9. Outpatient Medicare Patients. Medicare does not cover prescription drugs except for a few exceptions. According to Medicare regulations, you are responsible for any drugs furnished to you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to you by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.

10. Other Acknowledgements

a. **Additional Provision for Admission of Minors.** I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

b. **Legal Relationship Between Hospital and Physicians. Most or all of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors**. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf and that I will receive a bill for these professional services that is separate from the bill for hospital services.

c. **Patient Visitation Rights.** I understand that I have the right to receive the visitors whom I or my support person designates, without regard to my

relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

I have been given the opportunity to read and ask questions about the information contained in this form as well as this section of the form, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _____ (Initial)

11. Patient Self Determination Act.

I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay. Please initial or place a mark next to **one** of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive		I have not executed an Advance Directive and do not wish to execute one at this time

12. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the hospital Privacy Officer designated on the Notice if I have a question or complaint.

Acknowledge: _____ (Initial)

Date: Time:	I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this Consent for Outpatient Services and Authorization for Medical treatment, and that I have signed this Consent for Outpatient Services and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. This agreement is in effect and applies to care and treatment received during this outpatient episode of care. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

Patient/Authorized Representative Signature: X_____ If you are not the patient, please identify your Relationship to the patient. **(Circle or mark relationship(s) from list below)**: Spouse Parent Legal Guardian Neighbor/Friend Sibling Healthcare Power of Attorney Other (please specify):_____	**Witness Signature and Title:** X_____ **Additional Witness Signature and Title:** (required for patients unable to sign without a representative or patients who refuse to sign) X_____

Lakeview Hospital Wound Clinic
Insurance & Billing Help Sheet

Dear Customer,

We want to thank you for choosing Mountainstar Wound Care and Hyperbarics for your services. In an effort to make sure you have a pleasant experience, we want to share the following information that is intended to aid you in understanding our billing process. We understand that this can be a confusing aspect of healthcare so we want to make sure that you have this information as we proceed with your care.

Lakeview Hospital physicians who practice at our facility are independent practitioners. *You will be billed separately for specific services* rendered such as Wound Care and Hyperbaric Medicine. You will be receiving two bills in the mail following your services: one from Lakeview Hospital and one from the physician's billing service.

HOSPITAL BILLING

The patient billing/payment address for Lakeview Hospital is:

Lakeview Hospital
P.O. Box 740757
Cincinnati, Ohio 45274

The Patient Account Service Center (PAS) located in Cincinnati provides our patients with customer service support, billing services, insurance follow-up and insurance claims appeals (when needed). If you can any questions regarding your **HOSPITAL** bill you can contact Customer Service Support at 1.800.260.4841

The National Patient Account Services Group (NPAS) assists with patients without insurance, patient accounts follow-up, monthly payment arrangements and patient portions due after insurance payment is received

The Customer Service Support telephone number is
1.800.377.2035
NOTE: They are not a collection agency

*** Financial counselors** located in the main lobby of Lakeview Hospital are also available to assist you. We would appreciate if responsible parties would track their own insurance claims, assist with the insurance follow-up, and pay on accounts once an insurance explanation of benefits has been received. Please feel free to call with any questions or concerns at 801-299-2530 or 801-299-2531.

PHYSICIAN BILLING

The physician billing/payment address is:

PHYSICIANS BILLING SERVICES
3303 South Meridian Oklahoma City, Ok 73119

If you have questions regarding the physician's billing, please contact them at 1.800.962.3303.
Lakeview Hospital employees are not able to answer questions regarding physician billing.

Thank you very much for your understanding. Please let us know ahead of time if you have any questions.