Assignment of Benefits
Form and Consent for Care

Consent for Care: I am presenting myself for admission to the outpatient care at Riverwood Healthcare Center (hereunder referred to as RHCC) and I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by authorized agents and employees of RHCC, by its medical staff or their designee, as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment on my condition. I consent to the presence of students, consultants, and appropriate staff during all tests, examinations, medical treatment and other services provided to me at the hospital. I understand that while receiving care, accidental exposure to my blood or other blood fluids may occur. If this rare event occurs, I understand that my blood will be tested for the presence of Bloodborne Pathogens (Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus). These tests are necessary to help protect and counsel the exposed individual. I understand that results of the tests will not be a part of my medical record and will not be released except with my prior consent or as required or permitted by law.

Assignment of Benefits: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by RHCC, including physician services, or by any provider under contract with RHCC or participating in a provider network in which RHCC or its affiliates participate.

Important Information for Patients: I received the material on each line initialed below.

_____ Notice of Privacy Practices (unless received during previous visit)
_____ Federal and State Patient Rights Information (inpatient visit only)
_____ Health Care Directive Brochure (inpatient visit only)
_____ Important Message from Medicare (inpatient visit only)

_____ _____ _____
Signature of Patient, or if Patient is unable to sign, Representative of the Patient — Date — Time

_____ _____
Relationship to Patient (if patient is unable to sign) — Reason Patient Unable to Sign

Guarantee and Agreement to Pay

NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below.

I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that payment is due upon receipt of billing. Accounts are considered past due after 30 days from receipt of billing. If the account is referred to an attorney or collection agency, the patient will pay an additional 30% attorney's fees and collection expenses.

_____ _____ _____
Patient, Legal Representative or Guarantor Signature — Date — Time
(Directed by Patient to sign on their behalf, having read this document to them)

Riverwood HEALTHCARE CENTER

Patient Name: _____

Patient MRN#: _____

Patient DOB: _____