PATIENT LABEL

CONDITIONS OF ADMISSION AND TREATMENT

Consent to Admission and Treatment: The patient acknowledges that he/she is suffering from a condition requiring hospital care and hereby consents, by virtue of his/her admissions, to the rendering of such care, which may include general nursing care, routine diagnostic procedures and such medical treatment as the named attending physician(s) or others of the facility's medical staff consider to be necessary. It is expressly understood that an Informed Consent will be obtained from the patient before any procedure/treatment requiring such consent is executed. The patient understands that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risk of injury or even death. The patient acknowledges that no guarantee has been made to him/her as to the result of the examination or treatment in the hospital. Finally, the patient further recognizes that all doctors of medicine furnishing services to the patient, including the radiologist, pathologist, anesthetist, and the like, are independent contractors and are not employees of the facility.

Release of Medical Records and Medical Information: I, the undersigned as the patient of his/her authorized representative, hereby authorize Omega Hospital, to release to my insurance company(is), to entities that provide care in post-acute settings, or other appropriate agency(is) that information which is necessary to validate this claim. Omega Hospital is also hereby authorized to release to my physician(s) who perform any services for me/the patient on a fee for service basis such information as is necessary for billing purposes. I understand that this information may include reference to drug or alcohol abuse if applicable.

Assignment of Insurance and Financial Responsibility: I do hereby authorize and assign payment of all insurance benefits, basic and major medical for this period of medical treatment to be made directly to Omega Hospital. I further authorize the provider of service to obtain payment information from my insurance carrier. I hereby also authorize and assign to Omega Hospital for this period of medical treatment, any benefits, rights, penalties, or attorney's fees which I presently have, or may have in the future under any Louisiana law, including Revised Statue 22:657, with respect to the assignment of benefits to Omega Hospital. I understand that I am financially responsible to Omega Hospital for all charges not covered by insurance payments and that all efforts for collection of these benefits are for my convenience and do not represent a guarantee of collection or a credit to my account until such time as payment is received by Omega Hospital. True copies of this authorization shall be as the original document.

Assignment of Benefits/Contract Physicians: I hereby authorize release of information by the contract physicians of Omega Hospital for Radiology, Anesthesiology, Pathology, Cardiology, and Pulmonology. I further assign payment directly to these physicians, by my insurance carrier, of all the benefits due on my billing herein specified or otherwise payable to me. I hereby also assign to these physicians for this period of medical treatment, any benefits, rights, penalties, or attorney's fees which I presently have, or in the future under Louisiana law, including Revised Statute 22:657, with respect to the assignment of benefit to these physicians. I understand that I am financially responsible to these physicians for all charges and my contract for insurance is between me and my insurance carrier.

Billing Policy: Fees generated by providers are not governed by the provisions of the patient's insurance policy. Payment is due at the time of service; however, in some instances we may agree to provide additional time and/or terms for payment. If you are actively enrolled as a member of a group that is contracted with your provider of service, then the terms and conditions of the agreement between your provider and your group will supersede this billing policy. Omega Hospital, LLC does not provide service to Medicaid enrollees. If you are enrolled in Medicaid we will attempt to refer you to a Medicaid participating provider.

Terms for Admission/Treatment: I understand that a required payment/admission deposit and/or acceptable hospitalization insurance is required for either treatment or admission to the hospital. If I am admitted as an inpatient, the total balance will be due on discharge with allowance made for insurance coverage approved and verified prior to discharge. Any exception to the above must be made before or at the time of treatment.

Surety Agreement: In accordance with the above terms, the undersigned patient and/or undersigned surety, do hereby agree upon demand to pay Omega Hospital and its agents or assigns whatever sums of money that shall become due on the account of the patient, and that such liability shall be joint and several. Additionally, the undersigned agrees that should it be necessary to collect monies due through an attorney, the undersigned agrees to pay reasonable attorney fees whether suit be brought or not.

Patient Certification, Authorization: I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act 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 of authorized benefits be made on my behalf to Omega Hospital.

Infections Disease Identification Consent: I consent to having blood drawn to identify possible infectious disease including but not limited to Hepatitis and/or HIV/AIDS virus or antibodies.

Omega Hospital, LLC and its physicians comply with HIPAA (Health Insurance Portability Accountability Act).

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS THEREOF AND HAS RECEIVED A COPY THEREOF.

______________________________	______________	______________
UNDERSIGNED (PATIENTS SIGNATURE)	**DATE**	**TIME**
______________________________	______________	______________
AUTHORIZED AGENT SIGNATURE/ RELATIONSHIP	**DATE**	**TIME**
______________________________	______________	______________
WITNESS SIGNATURE	**DATE**	**TIME**

Rev. 07/2018