University of Maryland Medical Center

Uniform Signature Guarantee

PATIENT IDENTIFICATION

CONSENT TO MEDICAL CARE AND TREATMENT: I consent to hospital care encompassing routine diagnostic procedures and medical treatment for the patient. Furthermore, if the patient is an obstetric patient admitted to the hospital for the delivery of a baby, I consent to hospital care of the infant(s) encompassing routine diagnostic procedures and medical treatment.

_____ **Telephone Consent**

INSURANCE NOTIFICATION AND ASSIGNMENT: I hereby certify that the information given by me in applying for payment under title six of the social security act, by my insurers, or by any other third party payors is correct. I assign to the University of Maryland Medical Center all hospital benefits due me under the terms of said policies and programs but not to exceed the hospital's regular charges for similar services. I assign payment to the physician(s) rendering medical services to the patient and I assign payment for the unpaid charges of the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am responsible for payment of any health insurance deductible(s), coinsurance, or any other charges incurred which are not paid by my insurers or other third party payors.

MEDICARE AUTHORIZATION: (IF APPLICABLE) I request payment of authorized medicare benefits to the hospital on the patient's behalf for any services furnished the patient by or in the University of Maryland Medical Center including physician services. I authorize any holder of medical or other information about the patient to release to medicare and its agents any information needed to determine these benefits or benefits for related services.

RELEASE OF INFORMATION: I hereby authorize any physician, hospital pharmacy, insurance company, employer or organization to release any information regarding the medical history, treatment, or benefits payable for this claim to any organization responsible for payment on this claim or to any physician or medical service organization who will render care to the patient after discharge from the University of Maryland Medical Center.

VALUABLES RELEASE: The hospital shall not be responsible for the loss or damage to any personal property of the patient brought into the hospital.

GUARANTEE OF ACCOUNT: I hereby acknowledge responsibility for this account and assume and guarantee payment of all hospital expenses incurred during this admission and/or visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the University of Maryland Medical Center to transfer and apply such credit on any outstanding account at the hospital incurred by myself or my dependents. Should this account be referred to an attorney for collection, the undersigned shall pay attorney fees of twenty-five percent (25%) and collection expense. It is understood that all judgements in a court of law may bear interest at the legal rate.

RECORDING OR FILMING: Recording or filming of patients may be conducted for internal organizational purposes such as education.

NOTICE OF INFORMATION PRIVACY PRACTICES: I ACKNOWLEDGE RECEIPT OF THE HOSPITAL'S NOTICE OF INFORMATION PRIVACY PRACTICES.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS. I ACCEPT THE ABOVE STATEMENTS. I AM EITHER THE PATIENT, THE PARENT OR LEGAL GUARDIAN OF THE PATIENT, OR OTHERWISE AUTHORIZED TO ACCEPT THESE STATEMENTS ON BEHALF OF THE PATIENT. I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS CORRECT.

THIS IS A NON-SMOKING FACILITY. SMOKING HAS SIGNIFICANT NEGATIVE CONSEQUENCES FOR YOUR HEALTH, THEREFORE SMOKING IS DISCOURAGED. HOWEVER, IF YOU CHOOSE TO SMOKE, THERE IS A DESIGNATED SMOKING AREA OUTSIDE. WE DO NOT HAVE THE STAFF TO ESCORT YOU TO OR FROM THE SMOKING AREA, NOR ARE WE ABLE TO MONITOR OR WATCH YOU WHILE YOU ARE IN THE SMOKING AREA. THUS THERE IS A RISK OF NOT BEING SEEN OR TREATED IF YOU NEED EMERGENT CARE. BY SIGNING BELOW, YOU ACKNOWLEDGE AND ACCEPT THE RISK OF GOING TO AN AREA WHERE YOU WILL NOT BE OBSERVED BY HEALTH CARE PERSONNEL AND THEY WILL NOT BE READILY AVAILABLE TO ASSIST YOU, IF NEEDED.

_____
PATIENT OR RESPONSIBLE PARTY NAME (PRINTED)

_____
PATIENT OR RESPONSIBLE PARTY NAME (SIGNATURE SEAL)

REASON IF UNABLE TO SIGN:

_____
WITNESS

_____ MINOR (UNDER 18 YRS.)

_____ PHYSICAL CONDITION

_____ MENTAL CONDITION

_____
DATE/TIME

CN19