Assignment of Insurance Benefits

I hereby authorize payment directly to the above named hospital for benefits herein specified and otherwise payable to me but not to exceed the hospital's regular charges for this period of hospitalization. I understand that these benefits will be applied to these charges and any other balance due the hospital and agree that I am financially responsible for charges not covered by this assignment. I further assign the benefits payable for physician services to the physician or organization furnishing the service. I also understand that a COPY of this authorization is as valid as the original.

Medicare/Medical Assistance Patients: I hereby certify that the information given by me in applying for payment under Title XVIII (Medicare) and Title XIX (Medical Assistance) of the Social Security Act is correct. Release of all records required to act on this request is hereby authorized. This release does not apply to information pertaining to Mental Health and Substance Abuse treatment clients. Payment of authorized hospital benefits on my behalf is hereby requested. I request payment of benefits for physician services to me or on my behalf to the party accepting assignment under the terms required by electronic medium billing, or as described on the appropriate billing form. My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws. I have read and agree with the above statement.

Release from Responsibility for Valuables Retained by Patient

I have been informed and understand that the Bradford Regional Medical Center maintains an appropriate place for safekeeping for any money, valuables or other personal effects while I am an inpatient and said hospital shall not be responsible for any loss of any such property during my period of hospitalization, which I have not deposited with the hospital for safekeeping.

Inpatients Only: Medicare/Champus

I acknowledge that I have received the important message from Medicare or Champus, whichever is applicable.

Consent to Hospital Care

I am requesting care and/or to be admitted to Bradford Regional Medical Center. While I am in the Bradford Regional Medical Center, I permit my doctor, the Bradford Regional Medical Center and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations, and medical and surgical treatment.

No Guarantees have been made to me about the outcome of this care.

I have received a Notice of Privacy Practices from BRMC or its affiliates at this visit or during a previous time of service.

If this visit is an inpatient or observation stay, I have received BRMC's "Patient Rights and Responsibilities." As an outpatient or Emergency Room visit, I acknowledge the posting of the "Patient Rights and Responsibilities" in the Registration areas.

This form has been fully explained to me, and I certify and acknowledge that I understand its contents.

SIGNATURE OF PATIENT	DATE	TIME	WITNESS

The patient is unable to consent because: _____
Therefore consent for the patient is given by:

SIGNATURE	RELATION TO PATIENT	WITNESS	DATE	TIME (AM / PM)

BRADFORD REGIONAL MEDICAL CENTER
BRADFORD, PA 16701

Assignment of Benefits / Valuables Release / Consent to Care

* A D M A S S I N B E N *

Old # 9250-449 11/06
(white – not ncr)
Rvsd 042811 Page 1 of 1
Form #: 3004112

Patient Identification