MEMORIAL HOSPITAL
1423 Seventh Street
Aurora NE 68818-1197
(402) 694-3171

CONDITIONS OF ADMISSION

MEDICAL CONSENT: I, knowing that I am suffering from a condition requiring hospital care, do, hereby voluntarily consent to such hospital care encompassing routine diagnostic procedures and medical treatment, by my physician, his assistants, or his designees as is necessary in his judgement, others of the medical staff of Memorial Hospital, including but not limited to RN, LPN, Aides, etc., which in his or their judgement becomes necessary while I am a patient in said hospital. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the hospital. I hereby authorize Memorial Hospital to retain, preserve, and use for scientific or teaching purposes or dispose of at their convenience any specimens or tissues taken from my body during my hospitalization.

STATEMENT OF PERSONAL VALUABLES: I acknowledge that the hospital maintains a safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss of or damage to any money, jewelry, glasses, hearing aids, dentures, documents or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss of or damage to any other personal property, unless deposited with the hospital for safekeeping.

CONSENT FOR RELEASE OF MEDICAL INFORMATION: I consent to release of protected health information for payment, continued care and health care operations purposes.

STATEMENT TO PERMIT PAYMENT OF HOSPITAL AND MEDICAL INSURANCE BENEFITS TO HOSPITAL: I certify that the financial information given by me is correct. I request that payment of authorized benefits be made to the hospital in my behalf.

FINANCIAL AGREEMENT: I hereby agree to pay Memorial Hospital for services rendered to me. I acknowledge that the hospital has the option to request payment of this amount upon my receipt of an itemized statement. I understand that long term patients are expected to pay their account as billed. If overpayment occurs by myself or medical carrier, I direct the hospital to apply this amount to other unpaid accounts I may have at the hospital or Memorial Health Clinic. I further understand and agree that in the event the entire unpaid balance is not paid within ninety (90) days from the date of discharge that I may be charged, and I agree to pay interest at the rate of twelve percent (12%) per annum on the unpaid balance. Medical assistance is available to all persons who make application and are determined eligible.

POLICY: It is the policy of Memorial Hospital and in accordance with Federal law that all persons in need of services are not discriminated against on the basis of age, disability, race, color, national origin, ancestry, religion, or sex. While the facility must receive payment of its services, the facility does not discriminate among persons based on the source of that payment.

SIGNATURE ON THE FRONT CERTIFIES THAT HE HAS READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT, TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS OF BEHALF OF THE PATIENT.

I HAVE read and understand the Conditions of Admission and FINANCIAL AGREEMENT as printed on this form. PATIENT OR PERSON AUTHORIZED ____ RELATIONSHIP ____ DATE ____ TIME ____ WITNESS ____	I acknowledge I have received Memorial Community Health's Notice of Privacy Practices. PATIENT OR PERSON AUTHORIZED ____ RELATIONSHIP ____ Patient Refused to Sign EMPLOYEE NAME ____ DATE ____ TIME ____

RE: 5/2010