Sarpy County OB/GYN, P.C.
1413 S. Washington St., Suite #270
Papillion, NE 68046
402-898-8500

CONSENT TO OUTPATIENT SERVICES

Authorization for Medical Treatment: I authorize the physician or therapist in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes, but is not limited to routine diagnostic procedures, rehabilitation therapy, laboratory tests, and x-rays. I acknowledge that no guarantees have been made to me as to results of my treatments, tests, or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician or therapist whose care the patient is under.

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 to results of examination and treatment in this Facility. I acknowledge that my care is under the direction of my treating physician and the Facility will follow the instructions of my physicians in the provision of said care.

Patient Rights: I, the undersigned, have received a separate document informing me of my rights and responsibilities as a patient,

Assignment of Facility Benefits: I/we assign all benefits to Sarpy County OB/GYN and authorize direct payment to Facility address, all insurance benefits or Medicare/Medicaid benefits to which I/we may be entitled. This assignment specifically includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injuries caused by a third party. I/we agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Statement of Responsibility: I understand that I am financially responsible to Facility as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignment, which charges may include any medical insurance deductibles and co-insurance. I understand that to sign as a Guarantor means that if the patient does not pay Facility for all charges due, I, as Guarantor, will be responsible for such payment.

Noncovered Medicare/Medicaid Services: Medicare/Medicaid have certain outpatient procedures that are excluded from coverage, including but not limited to those of routine diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare/Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible, the patient will be provided additional information with regard to these charges and limitations on a separate written form.

Authorization to Release Information to Insurance Company/Third Party Payor: I authorize Facility and any physician, therapist, practitioner, pharmacist, or other person, any hospital including Veteran's Administration or governmental hospital, any medical service, organization, any insurance company, or any other institution or organization to release any medical information about the patient necessary to determine any benefits which may be payable for this treatment.

Authorization for Quality Review: I acknowledge that it may be appropriate for Facility to review the overall care provided to patients prior to and following the patient's treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of healthcare provided to Facility patients. Therefore, I authorize the physicians and therapists and other healthcare professionals who cared for the patient at Facility to provide Facility with copies of records regarding my care that pertain to the treating diagnosis as needed for quality review purposes. This consent is valid for the care provided to me for up to 12 months before and after my treatment at Facility.

Personal Valuables: Facility shall not be liable for the loss of or damage to any personal property.

Assignment of Benefits: I assign to Physicians and Therapists and authorize direct payment to Facility, all insurance benefits or Medicare benefits to which we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injuries caused by a third party. I agree to pay Facility for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be valid as the original.

The undersigned certifies that he or she has read the foregoing or is the parent/guardian or is duly authorized by or on behalf of the patient to execute the above and accepts all terms.

Patient's Signature/Parent if Minor/Power of Attorney Date

Responsible Party's Signature (if not same as patient or parent) Date

Patient unable to sign because Witness to signatures