BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Registration Release Form

I agree to all procedures, hospital care, and treatment my doctor has ordered. My doctor may have help from other healthcare professionals.
My doctor may change my care to benefit my life or health.
Bronson has an electronic health record that allows my information to be shared with those who need access to provide, coordinate and/or manage my care.

I Agree That:

- I will ask questions. No one has made promises about my treatment or care.
- Tissues, body parts or specimens can be tested or used for research. They will be disposed of with respect.
- Students or staff may look at my treatment and medical records for teaching or research. Information identifying me will not be published unless I agree.
- If I am here to give birth, my doctor and other healthcare providers can give care to my baby.

I Understand That:

- The staff will double-check who I am. They will ask what I am having done. This is to keep me safe.
- Hospital staff may post or call my name unless I check the "NO" box. □ NO
- I have rights and responsibilities when I receive services. This information has been provided to me. Some doctors and their staff are not employees of Bronson. This includes:
  - Radiologists
  - Pathologists
  - Anesthesiologists
  - Emergency Room Doctors
- I know that Bronson is not responsible for their actions.
- An HIV (AIDS virus) test or other blood test may be done without my consent after someone who has helped in my care is exposed to my blood or other body fluids. An example of this would be a skin cut.
- My person and my belongings might be searched. This may happen if there is a reasonable belief that you have items or substances that could harm yourself or others. We take the safety of our patients and staff very seriously.
- My primary care physician may be notified of my admission.

Medical Information: I understand that Bronson may release my records to:

- Insurance companies, health plan, and claims processers.
- My doctor and others involved in my care.
- My employer if the services are requested by my employer.
- Anyone or any entity responsible to pay all or part of my bill.
- Bronson's Attorneys and their Agents.
- I know this can include information about drug or alcohol abuse, mental illness, HIV or related illnesses.

Assignment Of Rights: I assign to Bronson all rights to bill for services I receive. I give Bronson all rights to pursue payment of my bills. This means that Bronson can, for example:

- Send my bills to insurance companies and health plans. Communicate with them for the purpose of getting payment
- Appeal the denial of payment or an adverse benefit determination
- File a lawsuit to get payment of a bill
- Be involved in any lawsuit or proceeding which involves my bill
- This includes pursuing all costs, interests, penalties and attorney fees allowed by law. I give up all rights to settle, release, or retain monies for my Bronson bill. I give up the right to take any action which would compromise payment or reimbursement of my Bronson bill.

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My Other Authorizations And Agreements:

- I agree to assist Bronson with the pursuit of my insurance benefits. I will provide home and/or cell telephone numbers to Bronson.
- I agree to receive pre-recorded telephone calls from Bronson, its attorneys and/or their agents at any of these phone numbers.
- I also consent to receive text messages and/or e-mails from Bronson, its attorneys and/or their agents using any phone number or e-mail address that I provide. I understand that my consent is not required to get treatment.
- I agree to allow Bronson to contact the OB manager at _____ (referring hospital) with an update on my baby's condition, unless I check the "NO" box □ NO

My Responsibility For Payment:

- I am responsible to pay all Bronson charges not covered by insurance.
- There may be a difference between Bronson's charges and the amounts paid by insurance. I am responsible for paying the difference.

I agree to provide Bronson all insurance information and all financial information regarding my ability to pay. I understand that I am responsible for:

- Co-payments
- Deductibles
- Non-Covered Charges
- Some Medications

- I understand that even if I am in a Bronson bed, I may still be considered an outpatient. I understand that I may receive bills from Radiologists, Pathologists, Anesthesiologists or Emergency Room doctors.
- I understand that I am responsible to pay these bills if not covered by insurance. Bronson has no responsibility to pay them.
- I verify that the information I give to Bronson is correct.

Valuables:

- Bronson encourages patients to leave valuables at home or with a family member.
- I know I can deposit my valuables in a safe when I am admitted.
- I agree that Bronson is not responsible for valuables not deposited in that safe.

I have read this form. All my questions have been answered.

Changes or alterations to this form are not binding on Bronson Healthcare Group/or its affiliated entities.

Patient Signature: _____ Date: _____ Time: _____

Parent or Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____ Time: _____

Interpreter's Statement

I have interpreted this consent form to the patient, a parent, closest relative or legal guardian.

Voice/Video Service: _____ Interpreter ID #: _____ Date: _____ Time: _____

Interpreter Name *(printed)*: _____ Agency: _____

Interpreter Signature: _____ Date: _____ Time: _____