Mercy

Name:____

DOB:____________ MR#:____________ CSN#:____________

the empl[illegible]yer is fulfilling its oblig[illegible] [illegible] am financially responsible for charges not paid [illegible]

5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, includin[illegible] is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Soci[illegible] Health and Human Services to [illegible] for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release [illegible] Social Security Administration or its intermediaries or carriers any information needed for this or a rel[illegible] Medicare claim.

6. **No[illegible]** [illegible] Privacy Practices (NOPP), which describes [illegible] Mercy may use or disclose informat[illegible] treatment, payment and health care operations. The NOPP is considered part of this Ag[illegible]ent by this reference. I understand that the NOPP is only provid[illegible] first ti[illegible] receive services [illegible] hospital and is otherwise av[illegible] upon request [illegible] website.

7. **Ima[illegible]es and [illegible]** [illegible]rstand that Mercy may make and use recordings, films, or [illegible] educational pur[illegible]. I under[illegible] that Mercy may [illegible] services through mobile application, medical device, or other technology. I under[illegible] [illegible] video monitoring in patient care areas when [illegible] and in common areas for security purp[illegible]. I conse[illegible] to such images, technology and video monitoring [illegible]ges, a[illegible] to visitors or the public and will not be disclosed except as requir[illegible] by law.

8. **Legal Relationship between Hospital a[illegible]** [illegible] hospitalized, I am unde[illegible] care and [illegible] of my attendi[illegible] respo[illegible] res[illegible] of my provider or surgeo[illegible] obtain my inf[illegible] specific medical or s[illegible] procedures, or hospital services provided to me under inst[illegible] the provider.

9. **Clinic and H[illegible]** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I [illegible]derstand that if I o[illegible] do not follow the rules, Mercy may pursue corrective action.

10. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While [illegible] may maintain a safe for small personal items of usual value, Mercy is not responsible for the loss or dama[illegible] to these items.

Mercy

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11. **Demographic Information:** I have reviewed the de[illegible]graphic information listed for me and confirm that it is correct. I am aware [illegible] possible.

12. [illegible] Contractor/Provider: I understand that [illegible] professional services from non-Mercy providers such as [illegible]adiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.

13. **Phone Call[illegible] Messages:** I authorize Mercy and [illegible] or a representative I appoint, ab[illegible] contact inf[illegible] available to Mercy from third parties. I aut[illegible] m[illegible]ssage, and text message and authorize the use of automated dialing and texting technology an[illegible] under my phone plan. I ag[illegible]e such contact will [illegible] be "unsolicited" for purposes [illegible] state or fe[illegible] I agree that Mercy and its collection agencies may monitor and/or record any communication. If I wish to opt out of t[illegible]s Section 13, I understand that I may contact th[illegible] Mercy facil[illegible] received services.

A copy of [illegible] the original. The [illegible] patient or is duly authoriz[illegible] terms written abo[illegible] form is [illegible]

Signature: ______________________________ Date: __________ Time: ____________

If [illegible] relationship: ______________________________