SARATOGA HOSPITAL FINANCIAL AGREEMENT

I hereby authorize the Hospital to submit a claim to any third party, including but not limited to Medicare, Medicaid, workers compensation carriers, insurance carriers and/or health maintenance organizations, that might be responsible for payment for the care of, _____

at the Hospital. I further authorize the Hospital to disclose all or part of the medical records necessary to bill such third parties either by paper or electronic means, provided that such release of information is in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996.

I hereby assign to the Hospital moneys and/or benefits received from any third party for the care provided by the Hospital, including but not limited to payments from Medicare, Medicaid, workers compensation carriers, insurance carriers and/or health maintenance organizations.

I understand that I am fully responsible for payment for care provided by the hospital and agree to pay to the Hospital any amount that is not paid by an insurance carrier, government program or other third party. I also understand that Saratoga Hospital may make inquiries regarding my credit information when I have an outstanding balance or to evaluate my eligibility to participate in certain discount or other programs and that all such inquiries shall be "soft inquiries" unless otherwise indicated to me by the Hospital, meaning that such inquiries will not impact my credit score. I agree that Saratoga Hospital may make inquiries into my credit information and authorize Saratoga Hospital to request and review my credit report as part of those inquiries.

*** Vermont Residents: Consent to request a consumer report required by Vermont Fair Credit Reporting Contract Certification Supplement (9V,S,A, 2480e + 2480g)*

I agree that Saratoga Hospital and/or its agents may from time to time make calls and/or send text messages to you at any telephone number associated with your financial account, including wireless telephone numbers, that could result in charges to you. The manner in which these calls or text messages are made to you may include, but is not limited to, the use of pre-recorded/artificial voice messages and/or automatic telephone dialing system. You further agree that Saratoga Hospital and/or its agents may send e-mails to you at any e-mail address you provide us or use other electronic means of communication to the extent permitted by law. Consent may be revoked at any time and by any reasonable means that provide notice of revocation to Saratoga Hospital or its agents that have contacted you.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or is a representative of the patient duly authorized by the patient to execute and accept the terms of this Agreement.

_____	_____	_____
Date	Signature	Witness

_____
Relationship to Patient

MEDICARE AGREEMENT

Lifetime Reserve Days: I understand if I reach the maximum number of days for which Medicare will provide coverage for my hospitalizations, Medicare will pay an additional 60 days of hospital care subject to a daily co-insurance payment for which the patient is responsible. The 60 days are a lifetime maximum and will be permanently reduced by the days used. I wish to have my lifetime reserve days used for payments for this present hospital stay.

Medicare Assignment: I certify that I am entitled to Medicare benefits and that the information given by me in applying for payment under TITLE XVII (MEDICARE) of the SOCIAL SECURITY ACT is correct. I authorize release by Saratoga Hospital of information needed to act on this Medicare claim. I hereby assign and request that payment of authorized benefits for my hospital and medical care including unpaid charges of physician(s) for whom the hospital is authorized to bill in connection with its services and for certain in-house physician services by specialist, be made on my behalf to Saratoga Hospital. I understand I am responsible for any deductibles and co-insurance under this act.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or is a representative of the patient duly authorized by the patient to execute and accept the terms of this agreement.

_____	_____	_____
Date	Signature	Witness

_____
Relationship to Patient

The Saratoga Hospital

General Consent for Diagnosis and Treatment

DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

Consent: I, or (print name) _____ (for the patient) authorize and give my consent to the medical staff, their designates, and the staff of The Saratoga Hospital for such examination(s), therapy(ies), treatment(s), test(s), or procedure(s), to be performed upon me as, in their judgement, are necessary or advisable to my diagnosis, treatment, or care. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results or effects of any examination(s), therapy(ies), treatment(s), test(s), or procedure(s).

Release of Liability for Personal Property: I hereby release The Saratoga Hospital and its staff from all responsibility for any loss or damage to personal property not deposited with the Hospital's Security Office for safekeeping before services are rendered. I understand that the Hospital assumes no liability or responsibility for the loss or theft of any personal property I choose to retain during my hospital stay or other service, including but not limited to, jewelry, money, clothing, dentures, eyeglasses, and hearing aids. I further release The Saratoga Hospital from any responsibility with respect to any personal property that I may leave behind in the Hospital that is not claimed within 30 days of my discharge.

Staff: I understand that most of the physicians and other members of the medical staff of The Saratoga Hospital are not employees or agents of the Hospital, but rather, are independent contractors who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. Further, I understand that The Saratoga Hospital is a teaching facility and that my physician(s) may be assisted in my diagnosis and treatment by one or more students, physicians, nurses or other health care professionals in training.

Release of Information: I agree that The Saratoga Hospital and its medical staff may disclose all or part of my medical records to others in order to treat my condition, obtain payment for that treatment, and run Saratoga Hospital's normal business operations. My protected health information may also be shared with affiliated hospitals and health care providers so that they may jointly perform certain payment activities and business operations along with Saratoga Hospital.

Patients' Bill of Rights: I have received a copy of the Patients' Bill of Rights and understand that I can be assisted with any questions.

Notice to Our Patients: I have received a copy of the Notice to our Patients, which includes information regarding visitation and grievance.

This form has been fully explained to me and I am satisfied that I understand its contents and significance.

Print patient / Relative / Guardian Name	Signature	Date	Time
Relationship to Patient	Reason for Signature		
Print Interpreter Name (if required)	Signature	Date	Time
Witnessed by (print name)	WITNESS SIGNATURE	Date	Time
Witnessed by (print name)	WITNESS SIGNATURE	Date	Time

Two Witness Signatures are required for patient mark, telephone or verbal consent only