Memorial Hospital of Carbon County

COVID Drive-Up Screening Form

Please Print

First and Last Name: _____

DOB: _____ Sex: _____

Telephone number: _____

Email (for results to be sent to you): _____

Race: _____

Ethnicity: _____

Preferred Language: _____

Mailing Address:_____

Street Address: _____

City, State, Zip: _____

Staff only: Symptoms: Y N Priority: If Symptomatic – Y If Non-Symptomatic - N

Memorial Hospital of Carbon County

CONSENT FOR SERVICES

1. Rules
   I agree to abide by the rules of the hospital, including cooperation with the physician, physician assistants, and hospital personnel in my care and treatment and observance of the rights of other patients.
2. Guarantee of Payment
   For and in consideration of services rendered or to be rendered to this patient by Memorial Hospital of Carbon County, I/we individually and jointly, hereby agree to pay any and all bills rendered for said patient which are not covered by insurance and/or third party payers or otherwise paid together with all collection costs and expenses and reasonable attorney's fees. I understand and agree that all bills are payable and become due upon presentation. All delinquent accounts shall bear interest at the legal rate.
3. Assignment of insurance benefits
   In the event the patient is entitled to hospital benefits from any policy of insurance insuring the patient or any other party liable to the patient, the benefits are hereby assigned to the hospital. The responsible person and/or patient is responsible for charges not covered by this assignment. If you have health insurance, please understand that this is an agreement between you and your insurance company. The bill for services is an agreement between you and the hospital. You are ultimately responsible for payment of your bill regardless of the status of your insurance claim. The hospital will bill your insurance claim as a courtesy when information is complete regarding policy numbers or appropriate forms as required. If we do not have the billing information, the account will become your responsibility.
4. Authorization to release information
   I/we authorize Memorial Hospital of Carbon County to release medical and all other information as required for collections of benefits from insurance carriers, social security administration or its intermediary or third party source of payment in connections with the illness or injury of the patient and I do hereby release the hospital, attending physicians, and hospital employees from any and all liability in connection with the release of such information. I certify that the information given by me in applying for payment under title XIX of the social security act is correct. I request the payment of authorized benefits to be made in my behalf of Memorial Hospital of Carbon County.
5. Personal property release
   It is understood and agreed that Memorial Hospital of Carbon County is not responsible for personal property, valuables, and appliances retained by the patient on his/her person or in his/her room.
6. Consent for Care and Treatment
   I the undersigned do hereby agree and give my consent for admission to Memorial Hospital of Carbon County and consent to my physician, his/her associates, partners, assistants, designees, and hospital personnel to furnish medical or surgical care and treatment to
   _____ (patient name)
   As they consider necessary and proper in the care and treatment of the said patient for the purpose of diagnosing or treating his/her physical and mental condition. I also consent to the photographing or video taping of the operations/procedures to be performed including appropriate portions of my body for medical, scientific, or recording purposes.

Memorial Hospital of Carbon County

I HAVE READ THIS CONSENT TO CARE AND TREATMENT AND IT HAS BEEN EXPLAINED TO ME AND IN UNDERSTAND ITS CONTENTS AND ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULTS OF TREATMENT OR EXAMINATIONS IN THE HOSPITAL. I HAVE BEEN INFORMED OF MY PATIENT RIGHTS.

I HEARBY CERTIFY THAT I FULLY UNDERSTAND THE NATURE OF THE ABOVE.

ACKNOWLEDGMENT OF OPPORTUNITY TO RECEIVE AND REVIEW THE MEMORIAL HOSPITAL OF CARBON COUNTY NOTICE OF PRIVACY PRACTIVES AND PATIENT RIGHTS.

By my signature below, I am in agreement to the above general conditions for treatment. I am furthermore acknowledging the following:

- I have received and/or viewed the Memorial Hospital of Carbon County privacy practices.
- I have been offered but do not wish to receive and/or review the Memorial Hospital of Carbon County privacy practices. I understand that I may request a copy of the notice at any time and that Memorial Hospital of Carbon County and its medical staff will use and disclose my information as outlined in the notice of privacy practices without my signed acknowledgement of receipt of this notice.
- I have been informed of my patient rights.

Signature of patient: _____ Date: _____

If patient is a minor: _____ Relationship: _____

Signature of witness: _____ Date: _____

If patient is incompetent or unable to sign- give reason: _____

_____