HORTON COMMUNITY HOSPITAL

CONSENT FOR TREATMENT/CONDITIONS OF ADMISSIONS

1. MEDICAL AND SURGICAL: I hear-by consent to an x-ray examination, laboratory tests, medical or surgical procedures, including operations and anesthetics, which my physician(s) may consider necessary or advisable in the treatment of my case. If any anesthetic is necessary, I authorize it to be given by an anesthetist chosen by my physician(s). I agree to abide by the safety policies of the hospital.

2. PERSONAL PROPERTY: I understand that the hospital is not responsible for loss of or damage to clothing, jewelry or other valuables retained by me. Valuables may be submitted to the hospital for safekeeping. I further understand that the hospital is NOT responsible for dental appliances, eyeglasses, or like items retained in my possession while hospitalized.

3. RELEASE OF INFORMATION: I authorize Horton Community Hospital to release information regarding diagnosis as well as any other aspect of my care during hospitalization to any insurer that I have or may hereafter designate.

4. NEWS MEDIA RELEASE: I hereby grant permission to the Horton Community Hospital to release my name to the following for INPATIENT OR SWINGBED hospitalization:
   News media: **YES** ________ **NO** ______
   Hospital census board: **YES** ________ **NO** ______
   Clergy: **YES** ________ **NO** ______ **Preference:** ________________

5. INFORMATION BOARD: I authorize my health care providers to record data, which may include my name, nurse's name, date, therapy guidelines, allergies, activity privileges, dietary information, fluid restrictions, and specimens needing to be collected on a dry erase board in my room. The purpose is to foster communication between me, my family and persons providing care to me.

6. ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment directly to the Horton Community Hospital for the covered hospital benefits otherwise payable to me, including major medical benefits.

7. The Horton Community Hospital provides patient care services without regard to race, color, national origin, disability or age.

8. GUARANTOR STATEMENT: I hereby agree to pay for these services.

9. I have received a copy of the Horton Community Hospital Patient Rights, responsibilities and property.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENTS' GENERAL AGENT TO EXECUTE THE ABOVE AGREMENT AND TO ACCEPT ITS TERMS.

______________________________________ ______________________________

Patient's Signature Date

______________________________________ ______________________________

Patient's general agent/guardian's signature Relationship to patient

____

Witness