

**PART II:  
Release of Information,  
Assignment of Insurance Benefits  
and Financial Agreement**

**A. RELEASE OF INFORMATION, ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS:**

The hospital, my physician or physicians, may disclose all or any part of the patient record to any person who is or may be liable for or responsible for payment of all or part of the hospital's charges, including, but not limited to, insurance companies, medical or hospital service companies, workers' compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a Medicare or Medicaid claim. In consideration of the hospital's advancing or extending credit for hospital care services, the undersigned hereby assigns and transfers to Menlo Park Surgical Hospital all benefits and payment now due and payable or to become due and payable to the patient under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, worker compensation policy or program, employers and state welfare funds, or under any other benefit plan, for this period of hospitalization and related outpatient care. Furthermore, this assignment shall include any claims of bad faith. I request that payment of authorized benefits be made on behalf of the patient directly to the said physicians, radiologists and hospitals, and to any of their appropriate agents or divisions.

**B. RELEASE OF MEDICAL INFORMATION:** The undersigned agrees to the release of medical information to referral sources to facilitate communication between facilities that have and may provide care and to assist in the discharge process.

**C. FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, the patient is hereby obligated to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the patient shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

**D. INSURANCE POLICY:** I hereby authorize my insurance company to furnish all copies of my insurance policy to Menlo Park Surgical Hospital.

**E. RECEIPT OF COPY OF NOTIFICATION TO MEDICARE/MEDICAID EXCLUSIONS:** I certify that I have received a copy of the General and Specific Medicare/Medicaid Exclusions Form, which identifies the hospital charges that are not covered by Medicare/Medicaid.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
If Patient Unable to Sign, Patient Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured Policyholder's Signature

\_\_\_\_\_  
Month

\_\_\_\_\_  
Day

\_\_\_\_\_  
Year

\_\_\_\_\_  
Hour

a.m.  
p.m.

I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient or patient's legal representative, and the patient/responsible party appears to fully understand these conditions as stated.

\_\_\_\_\_  
Signature of Admission Personnel or Authorized Hospital Representative